Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 18 per fh 8897 11-3-09 vt
State of Maryland / Department of Health and Mental Hygiene 268
d Item 5 per fh, 8897, 1170 of the Certificate of Death

Reg. No. Amend Item 5 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2320 OCTOBER NORMA EDITH NEMPHOS 20. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE 8. Date of Birth (Month, Day, Ye 8/9/1923 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 005-22-8170 **Funeral** Days Hours Months 1 ☐ M 2 💢 F MAINE Director 055-22-8170 86 Usual Residence of Decedent Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits show d other than "natural", or Items 23a or 28a-f shovevent, the Medical Evaninar must be rediffed at MD 1 ☐ Yes 2 X No BALTIMORE Director PARKVILLE the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8368 HILLENDALE ROAD USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: ð 3 X Widowed 4 ☐ Divorced WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER YEARS 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be I Health and Mental ALIDA ဥ LUCAS GEORGE FOSSETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. MARSHA INSLEY/DAUGHTER PORT DEPOSIT, MD 21904
Date 20c. Location - City or Town, State 138 HONEYSUCKLE DR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ Removal from State 4 □ Donatjon 5 □ Other (Specify) PARKWOOD CEMETERY 10/27/2009 | BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. of Funeral Service Ligensee MO1139 Jom 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Theumonia Aspiration 3 weeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Oro 400N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed ear s 0 0 burial-trar Due to (or as a consequence of): Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o detached 9 I Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2 No 1 Tyes 3 Probably 4 Unknown Be Completed mic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate Acei lo Kena 2 🗌 No 1 ☐ Yes of Vital 1∐Yes 2∭ANo Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:  $1 \times 1$  Inpatient  $2 \square$  ER/Outpatient  $3 \square$  DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation Division 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier edicine D66 136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPSER CHESAPEAKE RR BEL AIR NNENNA UCHENBU 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 per Fh g897 11/3/09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar 34092 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October George R. Patrick 2009 08:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Intherville
If Inder 1 Year | If Under 24 Hrs. Heart Homes Assisted Living Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Virginia** 8. Date of Birth **Funeral** 1 ★ M 2 □ F Days Months Hours Min (Month, Day, Director 216<u>-10-6527</u> 1918 Usual Residence of Decedent 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector Maryland 1 Yes 2X No Harford Fallston ᡖ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3220 Suffolk Lane 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No 194

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ρ 1 Never Married 2 Married 1944 Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 Divorced Completed 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician Edgewood Arsn, 8 Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o မ Lonnie V. Patrick Helen Regina Fogelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other traus. Mr. Charles Patrick (Son) 3220 Suffolk Lane, Fallston, Maryland 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Wiseburg United Methodist 10/23/2009 1 Donation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Hall, Maryland Church Christory 10/23/2009 Write Hall, Marylan 22. Name and Armess of Facility Fvans Futeral Chapel & Cremation Services - Monkton 16924 York Road, Monkton Maryland 21111 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications t, it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any 1 oding 15 immediate cause. Enter Underlying Examine Due to (or as a cons ng physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ō Month Year Day been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? Yes 2 No 1 Yes within 24 hours after death,

To the Funeral Director: After this certific
completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? SSISTERLLO Hospital: 2 🗹 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 025205 and address of person who completed cause of death (Item 23a) (Type, Print) N. Chales St. Belto Md 21204 G'BMC 6701 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anthony G. Palmisano Ochober 18 2009 10:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Sex 1 ☑ M 2 ☐ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-90-0799 Months Hours Nov. 16,1957 51 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Martal Hygiene. Important: I flem 27 is manked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8814 Old Harford Road 21234 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, et 1 Never Married 2 Married δ Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Printing life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Journeyman/Pressman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore G. Palmisano ٥ Josephine C. Mosca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8814 Old Harford Road-Parkville, Maryland 21234 Josephine Misek/mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State Parkwood Cemetery Oct.21,2009 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS, FULL RAL, C 8800 harford Ro L CHAPEL AND CREMATION SERVICES ROAD-ParkVille, Maryland 21234 andrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician use as the burial Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year signed by the a P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2X No 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 1 hos funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completed (Check within 2 eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year,

address of person who completed cause of death (Item 23a) (Type, Print)

N.Charles

2. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34004 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year October 5:50a. M TTMar 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 20°JK timore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country)

Orth Carolina 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 N 213-52-0292 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 New 2 No Funeral Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1021 21202 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 2 NO 1 □Yes If Yes, Give Year or Dates: 1 □Yes 2 □V6 þ Specify Specify: BOCK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HIlied remical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Erdman MD21213 tittman-daughter Wanda Himne 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion 100 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myocardial inforction /Medical Due to (or as a consequence of): Examiner coronary artery diseas Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year signed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe After this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 1 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1🗖 Inpatient 2 ER/Outpatient 3 DOA 27. Ma rer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Certification: Division 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled hours to the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IMD Res-000 october iq, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Roshni Thakore I 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		Please	Type or Print in i AMEND ITEM#1 State of Marylar	Black Indelib 8&20b, perfind / Departme	le ink. Ensure / H. G897, 11/19/ nt of Health and	All Copies Ar	e Legible.	
		for State Registrar	•		te of Death		No. 2009	34005
Physic /Med		1. Decedent's Name (First, Middle, La	Poindexte	~		2. Date of Death Month	16 2009	3. Time of Death  5:10 AM
ges 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28e-f show of other traumetic event, the Medical Evant net must be notified at 10 pm.	by Funeral Director	4a. Facility Name (If not institution, gived to the control of the	Common  ex  M 2 of F  T. Age (la yrs)	Ast birthday) Yrs.  If Und Month Yrs.  Ity, Town or Location  10f. 2	ip Code  2 + 084  edent of Hispanic Origin? (secify Cuban, Mexican, Puer	th  8. Date of Birth (Month, Day, Ye.  8. 10g.	23 VI	olace (State or Foreign try)  Od. Inside City Limits  1  Yes 2 No
laryland 21215-0036 2 should be filed within 72 hours after deal and Mental Hygiene. Is marked other than "natural", or Items aumetic event, the Medical Examinatina	Be Completed	15. Decedent's Ec (Specify only highest grant Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	ucation	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of wo use retired)	rking 16b.	Kind of Business/Inc Pulaski urniture den Surname)	Plant
ylano buld be 1 Mental arked o	To B				unk Lucy M	cClanahan		Link
Vre, Maryland ss 1 and 2 should be file of Health and Mental Hy litem 27 is marked oth		19a. Informant's Name/Relationship (  Samy P)  20a. Method of Disposition	indexter	19b. Mailing Addre	ss (Street and Number or R	plin, VA	ty or Town, State, Zip	
Baltimore, permit. Pages 1 a Department of Hee Important: If Item eny Injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Service Licers)	Removal from State	Cometen, crematory of Lightands Me Emply		22/09 D uss Funer	ublin 1	/A
Ly Carolicate be executed by Medical Branch and Brysician and as the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consected.)  Due to (or as a consected.)	quence of):	ode of dying, such as cardia			Approximate Interval Between Onset and Death
O. Box he death ce the attendi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1  Live birth 2  Feta 4  Pregnant at time of	al death 3 Ectopic			23d. Date of delive	ery Day Year
cords, P. w requires that the speen signed by should be detacted.	by	Part II. Other significant conditions of	entributing to death but not res	sulting in the underlying	cause given in Part I.		co use contribute to the	
	Completed					24a. Was an autopsy performed 1 Tyes 2	prior to cor death?	psy findings available mpletion of cause of 2  No
of Vital Physicien: This certifica	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	TER/Outrotions 201	Other:	ath (Check only one)		
ng Phys ter this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 ☐ [ 28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how in		<u>Y)</u>
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide		M ome, farm, street, facto	1 □Yes 2 □ No	28f. Location (Street City or Town, St	t and Number or Rura tate)	d Route Number,
ne Hospital	Medical Ce	29a. Certifier (Check only one)  1 Certifying Ph 2 Medicel Exam	ysician: To the best of my kno ilner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date end place on, in my opinion, deeth occ	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due to	stated. the cause(s)
To th To th Comp	Me	29b. Signature and little of certifier	1. June		R08652		Date signed (Month,	
St		30. Name and address of person who was a superson w	32. Registrar's Signa	m 23a) (Type, Print) 95 Max ature	ROS652 Tholes O	r. Elkn	che Mo	1. 21075
Regist	rar	OCT 23 ZUUS	Charles A.	Marko				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 11:10 MPM 17, 2009 David Thomsen Popplein October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Hospital Baltimore If Under 24 Hrs. ] If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**2** M 2□ F Months Days Hours Min 87 Director 053-22-7538 Sep 06. 1922 Marvland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaniner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 3145 Cornwall Road 21222 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Health injury or other trainment. 1 ☐ Never Married 2 Married 1 to 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 B. G. & E. Boiler Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဨ Ernest Campbell Popplein Mary Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Mullins /Daughter 3145 Cornwall Road Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Oct 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 2009 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1442 Cremation and Funeral Alternatives Due Kitter 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic Obstructice disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Arthoroschorat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed rosclerch ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 □Yes 2 □ No is been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Zheiners 1 Yes 2 No 3 Probably 4 Unknown Completed v24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autonsy performe 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death

1 ✓ Natural 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No or Attend after death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated 29b. Signature and title of certifier track time! 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	Λ		For State Registrar	State of N	/larylan	d / Depa <i>Cei</i>	artment r <i>tificate</i>	of H	lealth a Death	and M	ental Hy	giene Reg. No.	2009	3 31	400
	Physici /Medic		1. Decedent's Name (First, Middle, Las Pradi	,	naik						2. Date of Dec Month Octobe	Day	, 2009	3. Time 9:4	of Death O A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, giv	e street and numbe	er)		4b. City, T	own, or	Location	of Death		4c. 0	County of Deat	h	
12			Holy Cross Hospit				Si If Under 1		r Spr If Under		0.5.1(5)		ntgome		
п	Funeral Director		5. Social Security Number 6. S 214-90-1566	ex KDM 2□F   7.7	Age (In yrs. I 56	ast <i>birthd</i> ay) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da January	23, 19	953 Ind	thplace (Star puntry) 1a	e or Foreigi
	ט		Usual Residence of Decedent												
	Marylan a-f show	ctor	10a. State 10b. County  Maryland Montg	omery		y, Town or Lo erwood									e City Limits es 2∭ No
	th with the 23a or 28 and be no	Funeral Director	10e. Street and Number 5913 Bowie Mill (	Court			10f. Zip (	ode 208	55			-	en of What Co ted Sta	-	
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventher must be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date:	s? ☑ No		1 □Yes 2	<b>∑</b> No	Specify:		cify Yes or No Rican, etc.)			s, etc. Asian	
21215-0036	ithin 72 h ne. Nan "nati	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation ade completed) College (1-4o 5+	or 5+)		dent's Usual kind of work DO NOT use						d of Business	Industry	
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anc	the find the ded of ed of even	Be	17. Father's Name (First, Middle, Last) Pranamath Patnaik								<i>(First, Middle,</i> Patnaik		ourname)		
Maryland	12 should be filed withir th and Mental Hygiene. 7 is marked other than traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event than the Mental traumatic event traumatic event than the Mental traumatic event traumatic event traumatic event than the Mental traumatic event ev	٦ ک	19a. Informant's Name/Relationship ( Ira Patnaik / Wif	Type. Print)			-		and Numb	er or Rura	Route Numb	er, City or			 5
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau <u>once.</u>	0_01	20a. Method of Disposition  1 □ Burial 2 🕅 Cremation 3 □  4 □ Donation 5 □ Other (Specif	Removal from Sta	le i	lace of Dispo emetery, crer	sition (Name	e of ner plac	e) 0	<u> </u>	er 25,	20c. Loc	ation - City or	Town, State	ı
Balti	permit. Pages 1 Department of I Important: If ite any Injury or ot		21. Signature of Funefal Service Licer	· · · · · · · · · · · · · · · · · · ·	M013	Ro	Name and	Addres	s of Facilit	ty Funera	al Home/ ethesda,	Bethes	da-Chev	z Chase	
	Physician /Medical		23a. Par 1. Enter the disease, or com shoc, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cardi	sed the death line. ac Arr	n. Do not ent								Approxir Interval	nate Between nd Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	Over1	uence of):									
68760,	rtificate be executed ng physician and as the burlat-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequ	ioma Ur uence of):	ıknown	Or	igin						
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Fetal tat time of d	death 3 [	☐ Ectopic pre☐ Other (spe		<b>V</b>			2	3d. Date of de Month	livery Day	Year
rds, P.	w requires that been signed be should be deta	ρ	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	nderlying car	use give	en in Part I				e contribute to		
of Vital Records,		Completed									24a. Was autor perfo	osy rmed?	death?	utopsy findin completion o	gs available of cause of
Vita	slcian: certific rector,	Be	25. Was case referred to medical examiner?	Harrison				100		of Death	(Check only o	ne)			
	Phy:	ion: To	1 ☐ Yes 2 🛣 No  27. Manner of Death 1 🛣 Natural 5 ☐ Pending	28a. Date of in (Month, in		ER/Outpatier 28b. Time of Injury		c. Injur	y at	2	ne 5 Resi			cify)	
Division	or Attenation after deation.  Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho etc. <i>(Specif</i> )	me, farm, str			165 2		8f. Location (: City or To	Street and vn, State)	Number or R	ural Route N	lumber,
	he Hospital in 24 hours a he Funeral I pletely filled	Medical C	29a. Certifier (Check only one)  1 ★ Certifying Ph 2 ■ Medical Example 1	ysician: To the be niner: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred a vestigation,	t the tir	ne, date a pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manner a place, and due	s stated. e to the caus	ie(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	ser	~	1 · D			e number	47			signed (Moni		
			30. Name and address of person who	completed cause o	f death (Item	23a) (Type,	Print)								

Registrar DHMH 17 Rev 1/2001

State

Nooshin Farr, M.D. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c, per DVR 8896 10/23/09 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Reynolds **Physician** AM EllaMae October 2009 /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore NA Johns Hopkins Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Age (In vrs. last hirthday) **Funeral** North C 1 M 2 F Months Days Hours Min 127 64-Director arolena Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exeminer must be notified at 1 Tes 2 □ No Director 2017maio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a di Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 12 No Specify Completed by Specify: 3 Widowed 4 Divorced "natural", lai 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, " was any injury or other traumatic event, " was any once." College (1-4or 5+) Father's Name (First, Middle, Last) (First, Middle, Maiden Surpan Be ೭ 19a. Informant's Name/Relationship (Type. Print) State, Zip Code) 27893 Onth Carolina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 0077 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltimore Maryla rematory 10-29-2009 4 ☐ Donation 5 ☐ Other (Specify) netro 21. Signature of Funeral Service Licensee DITH NUNYUN molzi Sacrimore Mary and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical iaw requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) P.O. 1 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 s page 2 autopsy The perform 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 TYes 2 🗆 No 2 ☐ Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and Merot certifier 29c. License number 29d. Date signed (Month, Day, Year) P23223 October 19 2009 30. Name and address of person who completed cause of teath (item 23a) (Type, Print) C Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21287 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			For State Registrar	State of Marylar		artment of F rtificate of I		/lental Hy	giene Beg No	2009	34009
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
e	Physici /Medic		Lenvert Earl	L Rhem				Month Octob	er 1	9, 2009	3:50 A <sup>M</sup>
-	Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or	Location of Death		4c.	. County of Deat	h
odl.			St. Thomas Moor			Hyattsv			P	rince G	
	Funeral		5. Social Security Number 6. S	M a D E	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 1	th ay <sub>o</sub> Year).	9. Birt	hplace (State or Foreign untry)
	Director		245-57-2107 Usual Residence of Decedent	71	113.			July 1	. ۵ ,	1930 Not	th Carolina
	/land iow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			_		10d. Inside City Limits
	a-f st	ctor	MD Prince (	George's Co	ollege	Park					1.24Yes 2. No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Co	untry?
	23a		4711 Berwyn House	Road		20740			USA	A	
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1		1 □Yes 2 🔼 No	Specify:			Specify:	Black
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modeal Exprines rust be notified at		15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. K	ind of Business/	Industry
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p	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name	e (First, Middle,	Maiden	Surname)	
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Mar	l 2 sh h and 7 is π traum		19a. Informant's Name/Relationship	**		ng Address (Street					Zip Code)
	ges 1 and 2 should it of Health and Men It if item 27 is marke or other traumatic		Rosemary Warner - 20a. Method of Disposition			Market Pl		ner, NC		529 ocation - City or	Town State
Baltimore,	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemoval from State		sition (Name of matory or other plac	1				_
≣	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature Funeral Service ☐ ☐			w Cemeter  2. Name and Addres		4-2009		ston, No ral Home	
Ba	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		A P 40	of brok		08 East B					
н			23a. Part 1. Enter the disease, or com	plications that caused the deat	·						Approximate
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	it a	Examiner	cause. Enter Underlying Cause (Disease or injury	Dus to (or as a conseq	uence of):						
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68760,	tificate be executed g physician and as the burlal-transit	edical		_ d							
Box		2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of del	ivery
	the death cer y the attendir ched for use	Physician/M	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		∃Ečtopic pregnancy ∃Other <i>(specify)</i>	у			Month	Day Year
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Hecords,	law I	Completed	Degrentio					24a. Was	osy	24b. Were au	topsy findings available
<u> </u>	: The	Co						perfo 1 ∐Yes	rmed? 2 No	death? 1 □ Yes	2  No
VItal	ician certifi ector	Be	25. Was case referred to medical examiner?	Hagaital		045	26. Place of Deat				
5	Phys	P.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatier		4 Pring Ho			6 ☐ Other (Spec	cify)
0	ding h. After fune	ertification:	1 Matural 5 ☐ Pending	(Month, Day, Year)	Injury	Work	yai (? Yes 2 □No	28d. Describe I	now injur	ry occurred	
Division	Atten deat ctor;	fica	3 ☐ Suicide 6 ☐ Could not b		l ome, farm, str			28f. Location (	Street an	nd Number or Bu	ıral Route Number,
É	al or a after a fine bid in b	erti	4 ☐ Homicide determined	building, etc. (Special	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tox			
	ospita hours inera ly fille	al C	29a. Certifier 1 Certifying Pr	ysician: To the best of my kno	wledge, deatl	n occurred at the tir	ne, date and place,	and due to the	cause(s	) and manner as	s stated.
)	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the physician of the funeral director, page 2 of the funeral director, page 3 of the funeral director, page 4 of the funeral director, page 5 of the funeral director, page 6 of the funeral directo	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and	d place, and due	to the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier	O		29c. License	e number		29d. Da	te signed (Montl	h, Day, Year)
			Shull	inclure	my	100	1852		De	Tuben 1	9 2009
			30. Name and address of person who	1-0= MA 45	m 12.	001161	y Rd H	Moutou	le 1	40 20	787
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	a. N. J			-		
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		For State Registrar	State of	Maryland	/ Depa	rtment of H	lealth and leath		ene 2009	34010
		1. Decedent's Name (First, Middle, Las	it)					2. Date of Death		3. Time of Death
Physicia Medic		Barbara Lou B.	Root					October	18,2009 Year	04:20A M
Examin		4a. Facility Name (if not institution, give		er)		4b. City, Town, or	Location of Deat		4c. County of Dea	
		Gilchrist Hospi	ce			Towson			1	Lto.
Funeral		5. Social Security Number 6. S		Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		g, Bir	thplace (State or Foreign
Director		196-24-0302 1 Usual Residence of Decedent	□м 2 🖁 F	79	Yrs.			November	7,1929 Ca	lifornia
nd how	ž	10a. State 10b. County		10c. City, 1	Town or Loc	ation				10d. Inside City Limits
aryla la-f s ified	Director	Md. Balt	0			Nottina	- h			1 ☐ Yes 2 🛣 No
or 28	ρ	10e. Street and Number	-			Notting 10f. Zip Code	nam	1	0g. Citizen of What Co	nuntry?
with t 23a st be	eral	3 Melken Court				21236			USA	,
eath tems	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. V	as Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian,
or it	by	1 Never Married 2 Married	Armed Force	X No		Yes, specify Cubar		to Rican, etc.)	Black, Whit	
urs aft tural",	Completed	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s.	1	☐ Yes 2X☐ No	Specify:		Specify: W	Mite
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partition (e) Marylating ZIZIO-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		William L. Root		Son		,				,
1 and 1 and 1 the item		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name of			40475-26 20c. Location - City or	
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Dan permit Depar Impor any in		MADIE							nam, Md. 2	
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	olications that cau	ised the death. I	Do not ente					Approximate
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Medical		resulting in death)	a. Due to (or	as a consequen	ne di:	JAME (			_	YEARS
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ath certifica attending pl	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnanc	v				1	
atten for u	ciar	in the past 12 months?	1 🗌 Live Bir	th 2 🗌 Fetal d	leath 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	Day Year
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tendi leath. lor: A the fu	iji	2 Accident Investigation 3 Suicide 6 Could not b					Yes 2 No			
or At or At after c Direct in by	Certificate:	4 Homicide determined	28e. Place of	Injury - At home etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
pital ours a eral [		29a. Certifier Certifying Phy	rigina. To the best	had any francisco	a - al 4b -		Table and the			
DIVISION VICE INC.  To the Hospital or Attending Physician: The k within 24 hours after death.  To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Medical	(Check 2 L Medical Exam	ner: On the basis	of examination ar	nd/or investi	gation, in my opinior	n, death occurred	at the time, date and	e(s) and manner as sta place, and due to the ause(s) and manner as	cause(s) and manner stated.
To the Vithir Comp	2	29b. Signature and title of certifier				29c. License	number	29	d. Date signed (Mont	h, Day, Year)
		> Gasizo Honi	لالنن أ ، ١٨			000	5947	1 1	0/18/09	
		30. Name and address of person who	completed cause of	of death (Item 23	3a) (Type, Pi	int)	D- / 1	, ,		
			UI, MD,	555	W. 7	onsan	10mi bol	vd, 160	WSUMIA	1) 21504
Stat Registra		31. Date filed (Wonth, Day, Year)	32 Regi	strar's Signatur	ha	Mad				071204
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08145 State of Maryland / Department of Health and Mental Hygiene Robert James Rose, Sr 2009 34014 Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 20, 2009 1324 hrs **Medical Examiner** Robert James Rose, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital Date of Birth (MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Country) Maryland Director 216–66–6346 47 05/18/1962 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 X No 23a or 28a-f shov Marvland|Baltimore Middle River Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 U.S.A. 10242 Bird River Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. timore, MD 21215-0036

it. Pages 1 and 2 should be filed within 72 hours after death wit riment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 2 yor other tranumatic event, the Medical Examiner must be 1. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married Yes 1 Yes 2 X No specify: Specify: White If Yes, Give Year 3 Widowed Divorced ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Automobile 12 Millwright 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Marie Leineweber Edward Mcdowell Rose, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Christie Lynn Rose (Wife) 10242 Bird River Road, Baltimore, Maryland 21220 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/24/2009 Baltimore, Maryland Holly Hill Mem. Gard. Donation 5 Other Specify 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart Physician Between Onset and List only one cause on each line Death /Medical Atheroslerotic cardiovascular disease Immediate Cause (Final disease aminer condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit requires that the death certificate be executed Physician/Medical 23a,27, permE, g896 10/30/09 TT attending physician or use as the burial -X UNPENDED AMENDED Box 68760, 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 No 3 Probably 4 ✔ Unknown þ Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? 1 V Yes ✓ Yes 2 26.Place of Death (Check only one 25. Was case referred to medical Vital Be examiner? Other<sub>4</sub> Hospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ŏ 28b. Time of Injury 27. Manner of Death Division 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: A

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29b. Signature and title of certifier

State 31. Date filed (Month, Day, Year)

arks

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E

Registrar

29d. Date signed (Month, Day, Year)

October 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Inf g897 11/6/09 TT State of Maryland / Department of Health and Mental Hygien 9

Certificate of Death

34012

			Registrar			CUI	incate or i	Dealin		leg. No.		
	Physici	,	Decedent's Name (First, Middle, Last)						2. Date of Dea Month		3. Time of Dea	
	/Medic		George			Rayl				$20^{\text{pay}}$ , $200^{\text{pay}}$		М
1	Examir	ier	4a. Facility Name (If not institution, give s					r Location of Death	1	4c. County of		
			Future Care North  5. Social Security Number 6. Sex		e (In yrs. last bir	thday)	Dunc	If Under 24 Hrs.	8. Date of Birtl	Balti	Birthplace (State or Fo	raian
П	Funeral Director			KM 2□ F		Yrs.	Months Days	Hours Min.	(Month, Day	(, Year)	Country) ennsylvania	i oigi i
	D		Usual Residence of Decedent						TI-PIII I	0/1525 1	arbyrvaria.	
	how		10a. State 10b. County		10c. City, Tow	n or Loc	ation				10d. tnside City Li	
	Ba-1 e	cto	Maryland Baltimo	re	D	unda	alk				1 ☐ Yes 2X	No
	ior 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?	
	23a	ra l	2023 Larkhall Road			1	2122			USA	A - Constant	
	Her de	nu	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces?		13. V	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecity Yes or No- o Rican, etc.)	Black,	American Indian, White, etc.	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Itam 27 is marked other then "naturel" or items 23s or 28s-1 show enty injury or other traumatic event, the Modical Examinar traumatic event, the Modical Examinar traumatic event, the Modical Examinar traumatic event.	by Funeral	3 ☐ Widowed 4 ☐ Divorced	1 □XYes 2 □ 1 tf Yes, Give Year or Dates:	10	1	☐Yes 2XINo	Specify:		Specify:	White ,	
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Ma	d 2 sl th an 7 is r traur		19a. Informant's Name/Relationship (Ty.) Catherine Raybon	wife				, Dundalk		nr, City or Town, St nd 21222		
ē,	Heel Heel tam 2		20a. Method of Disposition	4477	20b. Place of	Dispos	ition (Name of	0-4-	Bër 24,	20c. Location - Ci		
Baltimore,	ages ant of t: If I		1 ☐ Burial 2 ☐ X remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	•	atory or other plac cematory		1009		e, Maryland	l
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ivis	l or Attenation after deati	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, fa	ırm, stre	et, factory, office		28f. Location (S City or Tox		or Rural Route Number	
	ital or irs afte ral Dir led in											
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•			Kinutiz	W			039	relev		utane	121,2009	
			30 Name and address of person who co	empleted cause of o		+-	Print) RJ. B	saltime	e, M	2121	9	
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Christopher	Clayton	Rumpf

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	•		Usua	al Residence of Decedent	I10c C	ity, Town or Lo	cation					10	d. Inside City	Limits
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	r death or ite	Funeral		Never Married 2 X Married  Widowed 4 Divorced If	1 Yes 2 X No	0	Yes 2X				Specify:	Whi	te	
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	8760, ificate be	M/M		FEMALE: b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth	pregnancy 2	Fetal death	3 Ectop	ic pregnancy	,	Month			Year
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			- -	6)/1/6/1	the Her	174	50	O.C.M.E.			October	16, 200	)9	
1			3	30. Name and address of person who			111 Penn Stre	of Dalties	ore MD 2	1201				
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	Reg	Sta jistr		31. Date filed (Month, Day, Year)  OCT 2 3 2069		1. 1	arked							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2809 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician OCTOBER 21, 2009 WILLIAM CARROLL RYAN JR. 5:14 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**∑**M 2□F 16, 1928 Maryland Director 217-24-3789 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notified at 1 Tyes 2 No Director Bel Air Maryland | Harford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21015 USA 1507 Westview Court "natural", or items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: or i 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XNo Specify. 9 3 Widowed 4 Divorced White Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Electronic Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Anna Agusta Benser William Carroll Ryan Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1507 Westview Ct., Bel Air, Maryland 21015 Elaine F. Ryan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Pages 1 a 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Highview Memorial Gdn 10-24-09 Fallston, Maryland 4 □ Donation 5 ☐ Other (Specify) 21. Sign tu unera Service Licensee McComas Funeral Home, P.A. May 1317 Cokesbury Road, Abingdon, Maryland 21009 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Acute **Physician** atory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Devere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequance of) Examine burial-tran Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ned by the a ☐Yes 2☐No Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 21 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Medical Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 063420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Dr. Khara 32 Registrar's Signatu Day, Year) 31. Date filed (Month. State Registrar

DHMH 17 Rev 1/2001

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mo000

William

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 10 1044 9M Smith eahor 09 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Himore Shock If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 🗸 F 219-12-6468 etober 21,1925 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1∩a State 1 ☐ Yes 2 ☑ No Maryland Anne Arundel BURNIE GLEN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1).S.A 7756 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ☑No Specify: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A.A.County Board of Education todia EnginEER GTH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELCANOR 1 FARMON MILLER WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7756 Solley Rd., Glen Burnie 21060 , MD SMITH (DAUGH) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CHEN HAVEN CEMETERY 10/17/2009 Glen Burnie, MARYland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
505CPH H. BROWN JR. FUNCRAL HUME 21. Signature of Funeral Service Licensee SUSCIPH H. BROWN SK., BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tracranial one day disease or condition resulting in death) Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

Pages 1 tment of t

**Physician** 

/Medical

Examiner

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hyglene.
is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

traumatic event, the Medical Everterer ust be redified at

**Funeral Director** 

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Completed

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Physician: The law requires that the death certificate be executed

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P.O. Box 68760,

Records,

Vital

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Division

the Hospital or Attending

death.

after death

within 24 hours a To the Funeral C

Medical

State Registrar

Physician/Medical É Completed Be Certification: To in by the

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

> 1030 am 10/10/09

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

tell at home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

3 Suicide

29a Certifier

4 ☐ Homicide

29c. License number 060292 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Circe 31. Date filed (Month, Day,

6 ☐ Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08141 State of Maryland / Department of Health and Mental Hygiene Russell Street 3401 2009 Certificate of Death 1. For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 20, 2009 1000 hrs **Medical Examiner** Russell Street c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NA Baltimore 717 Druid Park Lake Drive, Apartment 904 9. Birthplace (State or 8 Date of Birth(MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Country) MD Months Days Hours Director 11-10-57 51 1X M 2 219-68-1970 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location XX Yes 2 No s 23a or 28a-f show notified at once. MD NA Baltimore death with the Maryland 10g. Citizen of What Country? 10f. Zip Code Apt. #904 10e. Street and Number 717 Druid Park Lake Drive USA 21217 14. Race - American Indian, Black, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S White, etcAfrican Armed Forces? 1 XXNever Married 2 Married Yes Specify: American Yes 2 X No specify: 1 and 2 should be filed within 72 hours after If Yes, Give Year 3 Widowed Divorced <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) If item 27 is marked other than " her traumatic event, the Medical unk. NA Welding Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Street Be John H. Thompson Queenice of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 19a. Informant's Name/Relationship (Type, Print) 1519 North Fulton Avenue Baltimore, Regina Kohl - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 10-22-09 Pages Catonsville, MD Metro Crematory Donation 5 Other Specify 22. Name and Address of Facility 21. Signatore of Funeral Servi Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death Complications of chronic alcohol use Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician a be detached for use as the burial -X UNPENDED AMENDED 23a,27,permE, g897 11/10/09 TT Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available Records, 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 1 🗸 Yes page 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical of Vital Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 Inpatient 1 Yes After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Division Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

ORIGINAL

most

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 21, 2009

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registra

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

1

29b. Signature and title of co

31. Date filed (Month, Day,

Victor Weedn MD JD

23

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CURTIS BRADFORD SOUTHWICK OCT 2009 4:37 P M 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep. 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F Hours Yrs. 200-34-5625 1945 Pennsylvania 64 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 Is marked other than "natural", or Items 23a or 28a-f shov r traumatic event, the find and Exeminar a ust by notified a 1 ∏Yes 2X No Director Virginia Stafford Stafford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Franklin Street 22556 23a U.S.A. 72 hours after death Funeral tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Follows.

1 XYes 2 No
If Yes, Give 1978 —
Year or Dates: 1995 1 ☐ Never Married 2 X Married Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🗓 No Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within I Hygiene. Stafford Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygienn Important; If item 27 is marked other the any injury or other traumatic event, the once. Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alton Southwick Elizabeth Bradford ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karlyn Southwick (Wife) Franklin St., Stafford, VA 22556 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burjal 2 ☐ Cremation 3 ☐ Removal from State 10/21/09 4 Donation 5 Other (Specify) Quantico Nat'l Cem. Triangle, VA 22. Name and Address of Facility
Mullins & Thompson Funeral Service 21. Sign sure of Juneral Service Licensee, un 1621 Jefferson Davis Hwy., Fredericksburg. VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG ADENOCARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed ician and burial-tran Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending phase as ti IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas Physician: The certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Inpatient 2 I ER/Outpatient 3 IDOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 2 Accident 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No after death Director: / Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide n 24 hou. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only onel within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0101058113 (VA) 30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 SAM WANKO CDR MC USN 31. Date filed (Month. Day, Year) 32. Registrar's Signature State backer Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 0400 M 15 200 October !harles Spease /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 216 · 78 · 5849 Usual Residence of Decedent 1 ☑ M 2 ☐ F 56 Maryland **Director** Oct 26,1952 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Injury or other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Director NIA Baltimore Cit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1205 ENSOF Street 21202 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RestaurenT COOK -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Mason Willie Gray OSA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health al Important: If item 27 is any Injury or other trau Street Baltimus MD 21202 1205 ENSUR Elizabeth 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Daurial 2 Cremation 3 Removal from State Mr. Cormel Cemetery Oct 23,2009 Dundaik, Marijand 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Renald H. Grayson Funeral Service
270 Fred Hittin Pass Buttomere Mi 21. Signature of Funeral Service Licensee Emald a Fred Hilton Pass Buttomore MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** LUNG DISEASE STAGE disease or condition resulting in death) /Medical Examiner MONTHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1∐Yes 2.21√No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Domer specify Itospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ..tent. ..ter death, ...al Director: Aff Division 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H4593/

OLD COMTRD Rand

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 299 1 - For State Registrar 34021 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month Dav **Physician** 9:10 P.M 2009 Louise Ellen Shower October 20, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manchester Long View Nursing Home
5. Social Security Number 6. Sex Carroll 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 1 DM 20XF 213-16-1091 87 July 30, 1922 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XX No Director Maryland Carroll Hampstead 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code with America 14. Race - American Indian, 2401 Bert Fowler Road 21074 of Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes Z No Baltimore, Maryland 21215-0036 Specify: White Specify Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Hygiene. Elementary/Secondary (0-12) Seamstress 6 Sewing Factory filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental is marked David Leonard Hossler Florence Yingling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is Nancy L. Koerner (Daughter) 2315 Harvey Gummel Road, Hampstead, Maryland 21074 Date 23, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 6 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) New Lutheran Cemetery 2009 Manchester, Maryland Signature of Fund | Service Lic 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. any 3296 Charmil Drive, Manchester, Maryland 21102 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immeriate Cause (Final disease or condition resulting in death) **Physician** -csehno /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No. 24a. Was an has autopsy perform 1∏ Yes 2 N or Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Horsing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Injury at Work? Division 1 Tural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide l or / To the Hospital < within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number
5 - 00542(8 296. Signa urg 29d. Date signed (Month, Day, Year) Malcalin ding Westminson MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaneur man Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1 - State of N	Maryland / Depa Cei	artment of He	ealth and N eath	/lental Hygi	ene 2909	34022
	Physicia		Decedent's Name (First, Middle, Last)     Thomas	Seaby			Date of Death     Month	Dav Year	3. Time of Death 14:15 Рм
	Medic Examir		4a. Facility Name (if not institution, give street and number,		4b. City, Town, or Lo		October :	4c. County of Deatl	1
	Funeral		Gilchrist Center  5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Towsol	Ω If Under 24 Hrs.	8. Date of Birth	Baltim	ore
	Director		217-52-8816	60 Yrs.	Months Days	Hours Min.	Month, Day, Y March 20	,1949 Mar	yland
	yland •f show ed at	ctor	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	the Mar or 28a- e notifia	Director	Maryland Baltimore  10e. Street and Number	Dunda]	Lk 10f, Zip Code		10	g. Citizen of What Co	1 ☐ Yes 2 🂢 No
	th with ins 23a must b	Funeral	1908 Washington Road		21222			USA	
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  To filed the mode of the filed within "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Be Completed by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Deceden Armed Forces 1 □ Yes 2 V 1f Yes, Give Year or Dates.	Ž No	Was Decedent of Hisp If Yes, specify Cuban, I ☐ Yes 2 ☐ <b>X</b> No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
15-(	i 72 hou an "nati Medica	mplet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done duri O NOT use retired)		ing	6b. Ki <i>n</i> d of Business I	ndustry
212	d within ygiene. her tha ht, the l	e Co	12 years College (1-4 or 2 years	3+)	blic Serv	ice Insp	ector s	State of M	aryland
land	l be filed fental H rked ot tic ever	To B	17. Father's Name (First, Middle, Last)  Robert A. Seaby			8. Mother's Name Patricia	e (First, Middle, Ma . Graham	iden Surname)	
, Maryland 21215-0036	id 2 should salth and N n 27 is ma er trauma	1	19a. Informant's Name/Relationship (Type, Print)  Judith Seaby wife					ity or Town, State, Zip Maryland 2	
Baltimore,	permit. Page 1 ar Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	e 20b. Place of Dispo cemetery, cren Bayview C	natory or other place)		per zij	Oc. Location - City or	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Furth all Service Linus e	22	Name and Address Connelly 1			Dundalk,P. Dundalk,Md	
Р	h sician/		23a. Par 1. Inter the disease, or complications that cause shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition	ed the death. Do not ente	er the mode of dying, s	such as cardiac o	r respiratory arrest	,	Approximate Interval Between Onset and — th
mer de	Medical Examiner		resulting in death)  Due to (or as	s a co <i>n</i> sequence of):	Cqr				morths
. V 3	d ansit	amine	cause. Enter Underlying Cause (Disease or iinjury	a consequence of).					
Box 68760	ate be executed ohysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last  C. Due to (or as	a consequence of):					<del></del>
6876	ing phy e as the	Med	IF FEMALE:					1	-
. Box 6	y the attending ploched for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
ds, P,O	gne d	া	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given	in Part I.	23e. Did tobac	2 No 3 Pro	the cause of death?
Division of Vital Records,	riie law ate has page 2	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Ital	certificate ha	BB	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Othor	of Death (Check	only one)		~ 1 1 · · · · ·
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Sion	ctor: A	Certificate	2 Accident Investigation 3 Suicide 6 Could not be	jury - At home, farm, stre	M 1 🗆 Yes	s 2 □ No	29f Looption (Street	et and Number or Rura	d Davida Numbar
	urs afte		building, e	tc. (Specify)			City or Town, S	State)	
A Linearity	within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Med	29a. Certifier (Check only one 3 Certifying Nursu Practioner I. II.	examination and/or investi	igation, in my opinion, o	death occurred at	the time date and r	place, and due to the co	ueo(e) and manner stated
ν <sub>Ε</sub>	0 0 With		29b. Signature and title of certifier MD		29c. License nu		29d	Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of Erro Bushmil, 6701 N.Ch	death (Item 23a) (Type, Pr			more,	MS, 212	204.
	Stat Registra		31. Date filed (Month, Day, Year OCT 23 2009 33 Registr	rar's Signatufe	Mad	1			

10/20/2009

Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. tems# 2 3 23b 23e & 26 per MD G896 10/23/09 TT State of Maryland / Department of Health and Mental Hygiene 2 1 9 1- For State Registrar #3perPHYS, C896, 10/26/09, WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Otth AM Day **Physician** Slade Mae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner andall stown Baltimore Hospita 6. Sex North West 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Age (In yrs. last\_birthday) **Funeral** Year) 6486 Months Min 1□ M 2 F NC Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho Baltimore 1 ☐ Yes 2 No Director OWINGS 194 Zip Code 10g. Citizen of What Country? Street and Number 160 2117 USA Spectator Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: ş Specify: 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Civilian Welfare Fund Representative Arm 2th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any light yor other traumatic event, once. 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hornes DUISE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lane Owings Mills, MD 21117 Slade Spectator tatricia Daugnter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Woodlawn, MD emetery 1013/09 Vaughin C. Greens Funeral SUCS 21. Signature of Funeral Service Licenses 22. Name and Address of acility Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ColoRectal **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) ガズじ P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, The law requires t \$ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 ☐Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice 2 No Hospital: ပ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA n 24 hours after death.

The Funeral Director: After this pletely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or 29a. Certifier f certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 P 29d. Date signed (Month, Day, Year) 29c. License number 200 who completed cause of death (Item 23a) (Type, Print) "OLD COURT Rd Randallstown MD 31. Date filed (Monti istrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Anthony Sousa, Jr. Ktober 9,200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17, 6 Sev 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 T F 1946 035-30-7617 63 Mass. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3149 Crittenton Pl. 21211 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. Affiled Foldes: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:**Vietnam** 1 Never Married 2√ Married White 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Collector Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked ott any lijury or other traumatic even once. Anthony Sousa, Sr. Blanche Salisburv ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Sousa (Wife) 3149 Crittenton Pl., Baltimore, MD 21211 20b. Place of Disposition (Name of cemeter), crematory or other place)
Baltimore Crematory

© Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 10/27/09 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Pa.1. — If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? upertension 24a. Was an autopsy performed? Yes 2 X No 065144 1 ∐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number 60581

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address.

31. Date filed (Month, Day,

100

Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Memoria

Hospital

person who completed cause of death (Item 23a) (Type, Print)

Union

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 8 9 9 34025 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** Straub Mary Ann 4:45 A M October 2009 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Agnes 8. Date of Birth (Month, Pay Year) Aug. 16, 1927 Maryland If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days 1 □ M 2 🖵 F 82 215-26-8043 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State d other than "natural", or items 23a or 28a-f show event, the Medical Evan from must be putified at 1 ☐ Yes 2 ☑ No Director Maryland | Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3308 Benson Ave. #142 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White g 3 

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If item 27 is marked other the any Injury or other traumatic event, Italians. 12 Insurance Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wivell Rose Keepers ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Travers 83 Shawgo Ct., Middle River, MD 21220 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery | 10/24/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part tenier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** Heart /Medical Due to (or as a consequence of): Examiner Amyteophic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 DXNo 1 ☐ Yes Hospital or Attending Physician; 14 hours after death. Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA ical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 20/2009 24064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cation MD-21229 900 2AR 31. Date filed (Month, Day, 32. Registrar's Signature Year State arte Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34026 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct 21. <sup>D</sup>2009 Year Catherine Spindler 2:40a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Catered Living of Cockeysville Cockeysville B ${ t altimore}$ | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | OeC . 214, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 578-42-9708 1 🗆 M 2 💂 F Mary land T931 Director Usual Residence of Decedent 28a-f shov 10b County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore 1 Yes 2 No Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10881 York Rd. #10 21030 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ๋k No If Yes, Give Year or Dates. ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Quality Inspector Kodak Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ဂ္ Department of Health and Ment.
Important: If item 27 is marked any injury or other. George Kleinhen Aline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Kleinhen (Brother) 1505 Pot Spring Rd., Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Loudon Park Cemetery 10/24/09 1 ABurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens 3620 Wilkens Ave., Baltimore, MD 21229 Part enter the mode of dying, such as cardiac or respiratory arrest, snock, or heartfallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ reast cana disease or condition years Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 No Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 No Other (Specify) Hospice ပ္ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director: the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifie

Marian Grant

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

N. Charles

32 Registrar's Signature

29c. License number

St. Towson, MP

R149194

29d. Date signed (Month, Day, Year)

Ochober 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 34027 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5:26A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A BALTIMORE CITY #404 5906 PARK HEIGHTS AVENUE, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 93 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Country UKRAINE 0571871916 214-98-0965 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo MD BALTIMORE N/A 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 5906 PARK HEIGHTS AVENUE, #404 21215 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 0 1 Never Married 2 Married ģ within 72 hours after Maryland 21215-0036 WHITE 1 Yes 2 XNo Specify. "natural", 3 Midowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) STATISTICIAN HUMAN RESOURCES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FAYGA SHAFFER SHTEYNBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 46 PICKERSGILL SQUARE, OWINGS MILLS, MD 21117 SEMA BLEKHMAN/DAUGHTER Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CHEVRA AHAVAS CHESED 10/22/2009 IRANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mett Ce 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or es a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the director, page 2 s autopsy Yes 2 🖟 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 💆 Residence 6 🗌 Other (Specify) 1 Yes 2 🔀 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 🗌 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Schip

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Oldio of Ma		Certificat				Reg. No.	2009	3402
	ıysicia Medica		1. Decedent's Name (First, Middle, Las Noma Toolan		-				2. Date of De Month	Day	Year 2009	3. Time of Death 6:00 A M
Ex	camine	er	4a. Facility Name (If not institution, given 416 W. Market					ocation of Deal	th	4c. 0	County of Death Worces	ster
	neral ector		237-24-8015	ex 7. Age ☐ M 2 💢 F	(In yrs. last birtl	nday) If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month, Da	th ay, Year) <b>2,191</b>	9. Birthp Count 9. North	place (State or Foreign htry) Carolina
Maryland	iffed at	ctor	Usual Residence of Decedent	imore	10c. City, Town	or Location			-	,	1	0d. Inside City Limits 1 □Yes 2 No
h with the	stbeng	al Director	10e. Street and Number 1723 Wycliffe	Avenue		10f. Zip	Code 2123	4		_	en of What Coun	try?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, After than "natural" or items 23a or 28a-f show	X	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 □ Yes			Specify Yes or No to Rican, etc.)		4. Race - Americ Black, White, e Specify: Whi	etc.
21215-0036 d within 72 hours aff giene.	the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2	lucation de completed) College (1-4or 5+	<del>,  </del> '	Decedent's Usu (Give kind of wa life. DO NOT u Clerk/ T	rk done du se retired)	ring most of wo	rking	1	d of Business/Ind	•
_ 0 _	ē	lo Be C	17. Father's Name (First, Middle, Last) McKinley Wood						me (First, Middle na <b>Haggin</b> :		Surname)	
Marylan  and 2 should be saith and Menta	er trauma		19a. Informant's Name/Relationship ( Pamela Nixon/		<b>I</b>		,		ural Route Numb	. ,	Town, State, Zip MD 21863	Code)
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments Important: If then 27 is marked	ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of cemetery Parkw	Disposition (Nai y, crematory or o rood Ceme	me of other place etery	, 10,	Date / 2 4/09		cation - City or To	
balt permit. Depart	any inj		21. Sign tu e of Funeral Service Licen	see MU	3	Evans F 8800 Ha	d Address uner	of Facility al Cha d Rd.	pel & Cr	emati e. M	ion Servio 21234	es
Physi /Med Exam	lical		23a. Part. Enter the disease, or com shock, or hear failure. List only Inmediate Cause (Final disease or condition ting in death)	one cause on each line	the death. Do note.  Consequence of	ot enter the mod	de of dying	, such as cardia	c or respiratory a	urrest,		Approximate Interval Between Onset and Death
bg/bu, rtificate be executed		cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of							
E 2	ω :	Pnysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 - Fetal death	3 ☐ Ectopic p 5 ☐ Other (sp		# # B		2:	3d. Date of delive Month	ery Day Year
requires that the death seen signed by the atter	uld be deta		Part II. Other significant conditions of Multiconfance			the underlying o	ause giver	in Part I.				ne cause of death?  ably 4 X Unknown
al Kecords,  The law requires t  cate has been signe	, page 2 sho	Completed by							24a. Was autoj perfo 1 □Yes		prior to con death?	psy findings available mpletion of cause of 2 □No
DIVISION OT VITAL HECK To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	funeral director	Certification: 10 Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day)	nt 2 ER/Out		Other 28c. Injury Work?	4 Nursing I	ath (Check only only only only only only only only	dence 6	XOther (Specific occurred)	Daughter's residence
UIVISION  al or Attending after death. I Director: Afte	d in by the	ertifica	3 Suicide 6 Could not be determined	and the second s	ry - At home, farr (Specify)	n, street, factor	415		28f. Location (	Street and wn, State)	l Number or Rura	d Route Number,
e Hospita 24 hours e Funera	oletely fille	Medical C		ysician: To the best on inner: On the basis of and manner stat	examination and							
To th withir	comp	Me	29b. Signature and title of certifier  C. Euror F.G.	Sin 97 W	-7		De pa				signed (Month,	
7			30. Name and address of person who		ath (Item 23a) (7	Type, Print)	U. N	Parket	- Stree	+	/	
Re	State egistra		31. Date filed (Month, Day, Year)  OCT 2.3 2009		r's Signature	well	- , //		0,770	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 6 9 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>D</sup>20<u>,2009</u> **JOHN JESSIE** TEMPLE OCTOBER 7:50P M Medical 4b. City, Town, or Location of Death TOWSON 4a. Facility Name (if not institution, give street and number, 4c. County of Death
BALTIMORE **Examiner** GILCHRIST HOSPICE CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral XX**M 2 □ F Months Days Hours Min 3-13-1941 219-40-7559 68 Yrs MARYLAND Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director PA FRANKLIN CHAMBERSBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 649 N. FRANKLIN STREET 17201 death with LOT 78 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 X Married ģ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify "natural", If Yes, Give 3 Widowed 4 Divorced WHITE Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Т. MACHINIST WM. BURNETT & CO Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 1 and 2 should be file f Health and Mental H item 27 is marked of ည GORDAN TEMPLE ANNA (RAAB) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17201 item 27 FRANCES JANE TEMPLE/WIFE 649 N.FRANKLIN ST LOT 78 CHAMBERSBURG, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 permit. Page 1
Department of I
Important: If it
any injury or o
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 10-23-09 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death elorecta Physician, Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 3 in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown detached g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law rafter death. Director: After this certificate has b autopsy performed 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 🗌 Yes 2 (2)No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No M Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Hospital

State Registrar

completed

24 1

within 2

Medical

29a. Certifie

(Check

30. Name and add

MANON 31. Date filed (Month, Day, Year)

only one 29b. Signatur

title of certifier

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

N. Charles

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 for State Registrar Certificate of Death 3. Time of Death 1. Desedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 130A ZOC /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Itimore Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday Social Security Number **Funeral** Days Months 1 ☐ M 2 🔀 F 219-66-5500 -11-195 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modes! Event har mark be putilled at once. 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Arlinaton Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 No 1 □ Never Married 2 □ Married 1 Tyes Specify. þ Hlac 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) 18. Mothers Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) Johnson T. Toe. Date 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 10-30-2009 Baltimore, M **™** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signat re d Funer I Service Licensee Stricker Street, Bayto MD 21223 heo! 55. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Motastatic Glomyo sarcoms **Physician** disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Silv to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ANo 1 ☐ Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deatl Injury 1 Natural 1 ☐ Yes 2 ☐ No

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, as nse certificate To the Hospital of within 24 hours at To the Funeral Completely filled

Baltimore, Maryland 21215-0036

cate has been signed by the page 2 should be detached our after death.

eral Director: After this certific filled in by the funeral director,

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Randallstown

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) OGY 20.2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bur )ebbic ton 5401 OLOCOURT

31. Date filed (Month, Day, Year)

OCT 2 3 2009

29b. Signature and title of certifier

29a. Certifier

3. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08036 State of Maryland / Department of Health and Mental Hygiene Thuron Thomas 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 16, 2009 0852 hrs **Medical Examiner** noma 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Pikesville 8 Breton Hill Road #2B 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Foreign Davs Hours Months Director Country) 1 M Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Yes 2 No or 28a-f show tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the <u>Medical Examiner must be notified</u> at once. permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Never Married Yes 2 No Yes 2 No specify: Widowed Divorced If Yes, Give Year or Dates: Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) (Street and Number or Rural Route Number, ၉ 19b. Mailing Address ton 20c. Location - City o Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) 2 Cremation Burial 3 Removal from State 231 Important: Donation Other Specify uneral Service Licens Signature of Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ No 3 Probably 4 V Unknown 1 Yes 2 Diabetes, Renal Disease Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed page Yes 2 V No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be Hospital: 1 Other; Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient After this 1 ✓ Yes ۵ 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work Certification: 1 V Natural Yes 2 No death. Pending the Director: 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the l 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 21, 2009 O.C.M.E.

State Registrar DHMH 17 Rev 1/2001

OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

<u>OCT-23</u>

Assistant Medical Examiner

32 Registrar's Signature

ÓŔIGINAL

111 Penn Street, Baltimore, MD 21201

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31.022

	1- For State Registrar	Ce	ertificate of	Death		Re	g. No.	
Physician edical Examine	1. Decedent's Name (First,	Middle,Last) <b>TOWNSE</b>	ND			2. Date of Deat Month October 19	Day Year	3. Time of Death 0450 hrs
edicar Examine		titution, give street and number)		b. City, Town, or Lo	ocation of Death	00.000.	4c. County of D	eath
,	1616 Lorman Cou		last hirthday)	Baltimore  If Under 1 Year	If Under 24Hrs.	8 Date of Birt	h/MM/DD/YYYY\ 9	. Birthplace (State or
Funeral Director	5. Social Security Number 244-70-0315	1 M 2 X F 64	s, last birthday) Yrs.	Months Days	Hours Min.	01/15	/1945 Fo	Country) NC
. du	Usual Residence of Deceder 10a. State 10b. Co		ity, Town or Location	on				10d. Inside City Limits
Maryland 28a-f show any d at once.	MD		BALTIMORI	E				1 X Yes 2 No
the Maryland or 28a-f sh	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What USA	Country?
ith the 23a or notific		CT.  12. Was Decedent Ever in	U.S. 13. Was	21217 s Decedent of Hisp	anic Origin? ( Sp	ecify Yes or No		merican Indian, Black,
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once.	1 X Never Married 2	Married Armed Forces?  1 Yes 2 X No	If Ye	es, specify Cuban,	Mexican, Puerto		White, e	
s after c	3 Wildowed 4	Divorced If Yes, Give Year or Dates:	1	Yes 2X No		work done	Specify: <b>B</b>	
61 3 - 3		(Specify only highest grade completed) 0-12) College (1-4 or 5+)		ost of working life. [				,
5-0036 ed within 7 tygiene. other than	Elementary/Secondary (  10  17. Father's Name (First, M		HOMEM			(First Artifical)	FAMILY	
三型 海出る マーノ		fiddle, Last) HUR TOWNSEND		1	8.Mother's Name MAGGI		Maiden Surname) TERSON	
2121 hould be f and Mental is marke	19a. Informant's Name/Rel	ationship (Type, Print )	19b. Mailing	Address (Street	and Number or F	Rural Route Nur	mber, City or Town,	State, Zip Code)
MC 2 slatth au alth aums	PATRICIA T.	THOMPSON/DAUGHTER	b. Place of Dispos			Date	20c. Location - Ci	
F F F	1 Burial 2 X Cre	mation 3 Removal from State	crematory or oth METRO C	ner place)		26/09	BALTIMOR	E, MD
Baltimo permit. Page Department o Important: injury or ott	4 Donation 5 Ott						ORTON & S	SONS F.H. INC
	James	ase, or complications that caused the de	17	O1 LAURE	NS ST	BALTO.	MD 21217	
Physician /Medical	23a. Part I. Enter the disea failure. List only one				sucii as cardiac c	respiratory arr	est, shock, or fiedit	Between Onset and Death
Examiner	Immediate Cause (Final di or condition resulting in de			ease				
	Sequentially list conditions if any, leading to immediate		ce of):					_
	E cause. Enter Underlying ( E (Disease or injury that initi	Cause c.						
ecuted and transit		d						
' jai e	UNPENDED IF FEMALE:	AMENDED						
		23c. If yes, outcome of p	regnancy	etal death 3	Ectopic pregn	ancy	23d. Date of de Month	elivery Day Year
Box 68° e death certificate attending ed for use as	past 12 months?  1 Yes 2 No 9	4 Pregnant at time o	f d 4h	ther (Specify)			(8)	
	Part II. Other significant	conditions contributing to death but n	not resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
rices that the signed by	<u>a</u>							Probably 4 V Unknown
of Vital Records, ag Physician: The law requir Mret this certificate has been someral director, page 2 should	Completed					24a. Was	ppsy pri-	ere autopsy findings available or to completion of cause of ath?
Reco The law icate has	oo					1 Yes	2 ✔ No 1	Yes 2 No
Vital Reorgeniam: The his certificate director, page	25. Was case referred to examiner?	Hospital: 1 Inpatient 2	ER/Outpatien		of Death (Check	ng Home 5	Residence 6 🗸	Other: Scene
Ing Physi After this funeral dir	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of		ry at Work?		how injury occurred	i
<b>~</b> = : ` =	1 Natural 5	Pending Investigation			res 2 No	Opt I sertion	(Change and Number	or Rural Route Number, City
Division pital or Attendiours after death. eral Director: /	1 V Natural 5 2 Accident 3 Suicide 6 4 Homicide	Could not be determined (Specify)	At home, farm, stre	et, factory, office b	uilding, etc.	or Town,		or Rural Route Number, City
0 - 3 -	Z9a. Celtillei	iying Physician: To the best of my know cal Examiner:On the basis of examinati	wledge, death occu	urred at the time, da	ate and place, an	d due to the cau at the time, dat	use(s) and manner a e and place, and du	is stated. e to the cause(s)
To the within 2 To the complete	(Check only one) 2 Medic Medic 29b. Signature and Medic	and manner stated.		29c. Licens				d (Month, Day, Year)
	Man	hand MD		O.C.I	M.E.		October 20,	2009
	30. Name and address of Melissa Brassell	person who completed cause of death of MD Assistant Medical Exa		Penn Street, E	Baltimore. MI	 D 21201		
Sta	Melissa Brassell							
Regist								

			1 - For State Registrar	State of Ma	i yiaiic	Cer	rtificat	e of [	Death	wentar ny	Reg. N	2009	34033
	Physici		1. Decedent's Name (First, Middle, Last Renato E. Ve							2. Date of De Month Octobe	eath	Ž, 2009	3. Time of Death 8:10 A M
	/Medic Examin		4a. Facility Name (If not institution, give 8100 Connecticut		109		, ,	,	Location of Deat		4	c. County of De	ath
4	Funeral Director		5. Social Security Number 6. Sec			st birthday) Yrs.	If Under Months	•	If Under 24 Hrs Hours Min.		rth a <i>y, Y</i> ea	9. B	irthplace (State or Foreign Country)
	with the Maryland a or 28a-f show	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome  10e. Street and Number  8100 Connecticut			, Town or Loc	Ch 10f. Zip		Chase		-	Citizen of What C	*
215-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show scitcal Evanins frmust be notified at	Completed by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates: cation e completed)	ver in U.S	16a, Deceo	Was Deced f Yes, spec I □Yes 2	dent of His cify Cubar 2 No			0-	14. Race - An Black, Wh Specify: W	nerican Indian, ite, etc. hite
7	be filed within 72 ho ital Hygiene. d other than "natu event, me Modical	Be Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+	-)			e Pr	esident 18. Mother's Nar				orication
Maryland	should and Mer is marke aumatic	To	Edmundo Ventur  19a. Informant's Name/Relationship (T) Stefan R. Ventura/	rpe. Print)		l .	-		Yole				
saitimore, i	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	Removal from State	Mon	ace of Dispos metery, crem tgomer	sition (Name	ne of ther place	9) Oct	ober 23,	20c. l	Location - City o	
7	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last	ications that caused the cause on each line	conseque	Do not enter Cardion ence of): ence of):	er the mod	e of dying					Approximate Interval Between Onset and Death years
P.O. BOX 56/50,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	E   Fetal	déath 3□	] Ectopic pi ] Other <i>(sp</i>			X.12		23d. Date of d Month	Day Year
cords,	equires tha	ted by F	Part II. Other significant conditions con Pleural Effusion	_		ting in the un	, ,		n in Part I.				to the cause of death?  Probably 4 🖾 Unknown
al nec	i; The law r icate has b r, page 2 sh	Completed	Valvular Insuffi	ciency						24a. Was auto perfo 1 □ Yes	psy ormed?	prior to	autopsy findings available o completion of cause of es 2 \( \textsquare\) No
<u> </u>	yslclar is certif directol	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatier	nt 2 🗆 E	R/Outpatien	t 3 🗆 DO	Othe	26. Place of Dea	ath (Check only dome 5 ☑ Res		6 ∏Other (Sr	necify)
VISION OF	tending Ph eath. or: After th the funeral	Certification: T	27. Manner of Death  1 That Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day)	Year)	28b. Time of Injury	M 2	8c. Injury Work	at	28d. Describe	_		out,
	pital or At burs after d eral Direct		4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.		_				City or To	wn, Sta	te)	Rural Route Number,
	he Hos in 24 ho he Fun ipletely	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examinati	on and/or inv	vestigation,	, in my op	inion, death occi	urred at the time	, date a	nd place, and d	ue to the cause(s)
	To 1	Μ	29b. Signature and title of certifier	til -			29c	. License 576				ate signed (Mo	nth, Day, Year)
			30. Name and address of person who co	16 D / C	115 4	1	,			h.c1	-		
	Sta Registr		Gail L. Seiken 31. Date filed (Month, Day, Year)	22 Registra	's Signatu	uburn ure			104, Bet	nesda,	mary	yiand 20	7014

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Harold C. Witherite 18:30 2009 Oct. 18 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford County Upper Chesapeake Medical Center Bel Air If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 90 Pennsylvania 172-16-0157 1919 Sept. 2, Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffied at once. 1 ☐ Yes 2 No Forest Hill Director Maryland Harford County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21050 1 Colgate Drive Baltimore, Maryland 21215-0036 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1¥ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2**XX**No Specify: White Specify: <u>ک</u> 3 N Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Glenn L. Martin Elementary/Secondary (0-12) College (1-4or 5+) Crew Chief <u>Aircraft</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Young Clark Witherite 19a. Informant's Name/Relationship (Type. Print) Son Lin-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1444 North Bend Road, Jarrettsville, MD., 21084 Mr. William G. Farrington 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/21/2009 1 Burial 2 Cremation 3 Removal from State Bel Air, Maryland Bel Air Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services—Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee CUM (7 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to was a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-tran Due to (or as a consequence of): Witherite, Harold Moooo33. Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? s been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? 1 □ Yes 2 ○ No certificate 2 🗷 No 1 ☐Yes 25. Was case referred to medical 26. Place of Death (Check only one) After this certific funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No NIX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0043220 Celu GEORGE ISCHARUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 MPPER CHESAPEAKED 32. Prigistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

09-08076 Joh

n Woodfield			e of Maryland	/ Depar	tment of	Health						999	3 3	408
Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)	Cert	ificate of	Death			2. Da	Reg. ate of Death	NO.		Time of Dea	
dical Exami		John Albert Woodfie								onth Dottober 17,	2009 Year		1915 hrs	;
		4a. Facility Name (if not institution, of 2110 Brandy Drive	ive street and number)		41	c. City, Tov Forest I		cation of [			4c. County of Harford			
Funeral Director			Sex 7. Ag	e (In yrs. la	st birthday) O yrs.	If Under Months	1 Year Days	If Under 2 Hours	5 C	Date of Birth uly 11,	мм/dd/үүүү) 19 <b>2</b> 9	Foreign	(State o	
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Location	on						100	d. Inside Ci	ity Limits
	٦	Maryland Harford	County	For	est Hi	ill						1	Yes 2	2 X No
	Director	10e. Street and Number 2110 Brandy Drive				1						at Country?	>	
	eral D	11 Man Decedent Ever in U.S.			3. 13. Was	2 1050 U					nited States  14. Race - American Indian, Black,			
	Fune	1 Never Married 2 Marri	YX Yes 2 No			es, specify Cuban, Mexican, Puerto Rican, etc.)				White, etc.				
	اھ	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  15 Decedent's Education (Specify only highest grade completed) 16a. De				Yes 2 X			nd of work o	done 1	Specify: White  16b. Kind of Business/Industry			
	Completed					Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					,			
	dmo				Chief	hief of Bureau					Associated Press			
	Be C													
	P.	19a. Informant's Name/Relationship		,							er, City or Tow			
i, ME and 2 s ealth a tem 27 traums		Mrs. Diane Woodfiel  20a. Method of Disposition	<u>Spouse</u>		ZII C				Forest		Maryland 20c. Location -			
nore ages 1: nt of H it: If it		1 Burial 2 X Cremation		tate Ev	ans Fu	ier place) inera	l Cha	pel h	0/22	/2009	Forest H	ill, M	)	
Baltin permit. Pa Departmet Importan injury or		21. Signature of Funeral Service Lin			I aa N	lome and A	ddroop	of Engility						ir
		Jew Jun	mplications that cause	d the death	Do not enter th	Newpo	ort	Driv	P FORE	est Hill	Mary Ia	210	50 Approximat	te Interval
Physician /Medical		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Intraoral Gunshot Wound												
aminer		or condition resulting in death)  Due to (or as a consequence of):												
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
ed sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
e executed sian and rial - transit														
760, cate be physici	/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	ome of preg			2	Estania	programme		23d. Date of		,	Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months?    1												
P.O. BC that the dea ned by the a detached fo	Phys	Part II. Other significant conditio	9 Ulikilowii	ath but not r	esulting in the ι	underlying	cause gi	ven in Pa	rt I.	23e. Did to	pacco use contr	ibute to the	e cause of	death?
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	d by					-				1 Yes	2 No 3			
	Completed									24a. Was a autops perfor	sy	Were autop prior to cor death?		s available cause of
	S						O Dines	of Dooth /	(Check only	1 Yes 2	2 ✔ No 1	Yes	2 [	No
	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpa	tient 2	ER/Outpatient			Other <sub>4</sub>	Nursing H		Residence 6	✓ Other: S	Scene	
	ı.	27. Manner of Death	28a. Date of Ir	njury /,Year)	28b. Time of FOUND:	Injury 2	_	y at Work	Su	d. Describe h ibject shot	ow injury occur self	red		
Sior Attend r death. ector: by the	catic	1 Natural 5 Pending Investigation 2 Accident Pending Investigation 2 Representation 2 Pending Investigation 2 Pending Investi						8f. Location (Street and Number or Rural Route Number, City						
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Residence 2010 Brandy Drive, Forest Hill, MD								Hill, MD				
Divis the Hospital or At hin 24 hours after of the Funeral Direc	cal													
To d Withi To d	Medical	and manner stated.  29b. Signature and title of certifier				29c. License number					29d. Date signed (Month, Day, Year)			
		When brand lims				O.C.M.E.					October 18, 2009			
1		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
	tate	Melissa Brassell, MD 31. Date filed (Month, Day, Year)		trar's Signat			. 551, 15		-, 2					
Regis			200d 6		4	1 .								

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State of Maryland / Department of Health and Mental Hydiene ? A A A

		For State Registrar  1. Decedent's Name (First, Middle, Last)	Cert	ificate of D	<i>Death</i>	2. Date of Dea		Voor	3. Time of Death		
Physicia	_	LEROY S. WHITE				Oct. 14	Day .	2009 <sup>Year</sup>	7:10 p M		
/Medic Examin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death				
		Montgomery Hospice Casey House	<u> </u>	Rockville			Montgomery				
Funeral Director		5. Social Security Number 6. Sex 1 2 F 7. Age (In yrs. le 142-74-6088 59	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day June 22	Year) 1950	Cou	place (State or Foreign intry) igua		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.	.	Usual Residence of Decedent  10a. State									
	Director	MD Prince Georges Ri	Le								
	ire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?					
	la l	6211 61st P1.		20737				r No- 14. Race - American Indian,			
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼ No Specify:				Black, White, etc.  Specify: Black			
	þ	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:	1								
	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede (Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired,	ing	16b. Kind	16b. Kind of Business/Industry				
	Com	Elementary/Secondary (0-12) College (1-4or 5+) 8th	Maint	ntenance			Village in the Woods				
	B	17. Father's Name (First, Middle, Last)				,					
	ျှ	Huebert Jackson Henriett									
		19a. Informant's Name/Relationship (Type. Print)		Street and Number or Rural Route Number, City or Town, State, Zip Code)							
		Mary N. White - Wife  20a. Method of Disposition 20b. P		61st Pl.		ale, Md.		3 / ation - City or	Fown, State		
rages nent of h int: If ite		1 ABurial 2 Cremation 3 Removal from State		ition (Name of atory or other plac Ln Cemete	1		Bren	twood,	MD.		
Departments Importa any inju		4 Donation 5 Other (Specify)  Ft. Lincoln Cemetery 10-24-2009 Brentwood, MD.  21. Signature of Funeral Service Licensee  Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitlnad, Md. 20746									
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.						Approximate Interval Between			
Physician /Medical	1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Anoxic Brain Injury									
		resulting in death)  Due to (or as a consequence of):									
xaminer		Sequentially list conditions  Hyroglycemic Coma									
is is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diabetes Mellitus						Į			
and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Diabetes Mellitus  Due to (or as a consequence of):									
incate be executed graphysician and as the burial-transit		d									
g phy as the	ledical	<u> </u>						l			
ath cer attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day Year			
ned by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertension					23e. Did tobacco use contribute to the cause of death				
signed d be det	d by						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 [				
s peen s	Completed		24a. Was	an	24b. Were a	utopsy findings availa					
s has	d d		auto perfe	ormed?	prior to completion of cause death?						
ficate or, pa		OF Was seen referred to modical		1 Yes 2 No 1 Yes 2 No							
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Be	25. Was case referred to medical examiner?  1 Yes 2 No						me 5 ☐ Residence 6 ☑Other (Specify) Hospic.			
	Ë										
	ij	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Mork? M 1 □Yes 2 □No								
office dear	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At he building, etc. (Special Could not be building).	ome, farm, stre fy)				n (Street and Number or Rural Route Number, Town, State)				
To the Hospital or within 24 hours afte To the Funeral Dirucompletely filled in											
o the northin 24 orther orthographete	Medical	and manner stated.						29d. Date signed (Month, Day, Year)			
- s - 0		J. 16 uest cheu,	063740			October 15, 2009					
		30. Name and address of person who completed cause of death (Iter Jocelyne Kouatchou, MD 6001	m 23a) (Type,	Print) ster Mill	Dd Doo	kuri 11 a	ма	20855			

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the invalidal Examination by notified at once.

Director

Funeral

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Completed

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Examine

Physician/Medical

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Be Completed

Medical Certification: To

Physician

Examiner

**Funeral** 

Director

/Medical

For State Registrar	OLGIO OI IVIC	C	ertificate	of Health and N of Death	Reg. I		34037
. Decedent's Name (First, Middle, Last	t)				2. Date of Death		3. Time of Death
Adella Wilson						Day Year Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	400 A M
a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of Death		4c. County of Death	1
RANKLIN SQUASE			Į —	ear If Under 24 Hrs.	T. O. D. M. (18) 11	Baltin	nplace (State or Foreign
Social Security Number 6. Se 85 22 3218 15 sual Residence of Decedent	<sup>3X</sup> 2	e (In yrs. last birthda Yrs.	Months D	ays Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 7, 194	ar) Cou	Mexico
Da. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
aryland Baltimor	e	Middl	le River				1 □Yes 2 No
e. Street and Number			10f. Zip Co		10g.	Citizen of What Cou	intry?
Maple Drive Apt.	A			220		USA	
. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		3. Was Decedent If Yes, specify 1 ☐ Yes 2 ☒	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: W	
15. Decedent's Edu (Specify only highest grad	ucation	(Gi	cedent's Usual O ve kind of work d e. DO NOT use re	one during most of worl		l . Kind of Business/li	ndustry
12	55/10g0 (1-101 5	.,	Housewi	ifę	0	wn Home	
7. Father's Name (First, Middle, Last) Saias Mendoza				18. Mother's Nam Antonia	e (First, Middle, Maid Torres	len Surname)	
9a. Informant's Name/Relationship (7 tanley E. Wilson				reet and Number or Ru ve Apt. A B			
a. Method of Disposition		20h Bloom of Dia					01-1-
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, c	position (Name of rematory or other ill Mem.	Gardens 10		Location - City or T altimore,	·
4 Donation 5 Other (Specify.  1. Signature of Funeral Service Licens  3a. Part 1. Enter the disease, or comp	see kee kee	Holly H	iematory or other ill Mem. 22. Name and A Bruzdzin 1407 Old	Gardens 10 Gardens 10 ddress of Facility ski Funeral Eastern Av	/26/2009 B Home P.A. venue Essex	altimore,	Maryland and 21221 Approximate
4 Donation 5 Other (Specify.  1. Signature of Funeral Service Licens  3a. Pa/t1. Enter the disease, or components, or heart failure. List only components of condition	see Character for the caused one cause on each line.	the death. Do not dee.	iematory or other ill Mem. 22. Name and A 3ruzdzin 1407 Old enter the mode or	Gardens 10 Gardens 10 ddress of Facility ski Funeral Eastern Av	/26/2009 B Home P.A. venue Essex or respiratory arrest,	altimore,	Maryland nd 21221
4 Donation 5 Other (Specify  1. Signature if Funeral Service Licens  23. Part 1. Enter the disease, or composition, or heart failure. List only commediate Cause (Final isease or condition esculting in death)	see plications that caused one cause on each lir a	the death. Do not do a consequence of):	iematory or other ill Mem. 22. Name and A 3ruzdzin 1407 Old enter the mode or	Gardens 10  ddress of Facility SK1 Funeral Eastern Av f dying, such as cardiac	/26/2009 B Home P.A. venue Essex or respiratory arrest,	altimore,	Maryland  nd 21221  Approximate Interval Between
4 Donation 5 Other (Specify  1. Signature if Funeral Service Licens  3a. Path 1. Enter the disease, or compendok, or heart failure. List only commediate Cause (Final isease or condition esulting in death)	b. Sep Due to (or as a c. P n e c.	the death. Do not dee.	ill Mem. 22. Name and A Bruzdzin 1407 Old enter the mode of	Gardens 10  ddress of Facility SK1 Funeral Eastern Av f dying, such as cardiac	/26/2009 B Home P.A. venue Essex or respiratory arrest,	altimore,	Maryland  nd 21221  Approximate Interval Between
4 Donation 5 Other (Specify  1. Signatury if Funeral Service Licens  3a. Part 1. Enter the disease, or composition of heart failure. List only of mediate Cause (Final isease or condition sesulting in death)  equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events is sulting in death) Last	b. Due to (or as a Due to (or as a d	the death. Do not dee.  A consequence of):  a consequence of):  a consequence of):  a consequence of):  of pregnancy  cometery, c  in the death. Do not dee.	ill Mem. 22. Name and A Bruzdzin 1407 Old enter the mode of	Gardens 10 ddress of Facility ski Funeral Eastern Av f dying, such as cardiac	/26/2009 B Home P.A. venue Essex or respiratory arrest,	altimore,	Maryland  nd 21221  Approximate Interval Between Onset and Death
4 Donation 5 Other (Specify  1. Signature of Funeral Service Licens  23. Part 1. Enter the disease, or compositock, or heart failure. List only commediate Cause (Final isease or condition esulting in death)  Requentially list conditions, any, leadin; to immediate ause. Enter Underlying ause (Disease or injury hait initiated events esulting in death) Last  FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ Hoo	b. Due to (or as:	the death. Do not dee.  The late of the la	ismatory or other ill Mem. 22. Name and A Bruzdzin 1407 Old enter the mode of	Gardens 10 ddress of Facility ski Funeral Eastern Av f dying, such as cardiac  ACCIDE	Home P.A. venue Essex or respiratory arrest,	altimore,  k, Marylan  23d. Date of deli  Month	Maryland  and 21221  Approximate Interval Between Onset and Death  very Day Year  the cause of death?
4 Donation 5 Other (Specify  1. Signatury if Funeral Service Licens  3a. Part 1. Enter the disease, or compositock, or heart failure. List only commediate Cause (Final sease or condition soutling in death)  equentially list conditions, any leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulfing in death) Last  FEMALE:  B. Was decedent pregnant in the past 12 months?  1	b. Due to (or as:	the death. Do not dee.  The late of the la	ismatory or other ill Mem. 22. Name and A Bruzdzin 1407 Old enter the mode of	Gardens 10 ddress of Facility ski Funeral Eastern Av f dying, such as cardiac  ACCIDE	23e. Did tobacc	23d. Date of delimonth  23d. Date of delimonth  couse contribute to 2 No 3 Process  24b. Were au prior to contribute a death?	Maryland  nd 21221  Approximate Interval Between Onset and Death  very Day Year  the cause of death?
A Donation 5 Other (Specify  Signature of Funeral Service Licens  Sa. Pat 1. Enter the disease, or comp silock, or heart failure. List only of the sease or condition is ulting in death)  equentially list conditions, any, leadin, to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last  FEMALE:  Bb. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  art II. Other significant conditions conditions conditions.	Due to (or as:  Due to (or as:	the death. Do not dee.  The late of the la	ismatory or other ill Mem. 22. Name and A Bruzdzin 1407 Old enter the mode of	nancy  given in Part I.	23e. Did tobacc	23d. Date of delimonth  23d. Date of delimonth  couse contribute to 2 No 3 Process  24b. Were au prior to contribute a death?	Maryland  nd 21221  Approximate Interval Between Onset and Death  very Day Year  the cause of death?  bably 4 — Unknown  topsy findings available completion of cause of
A Donation 5 Other (Specify  Signature of Funeral Service Licens  Sa. Fat 1. Enter the disease, or competions, or heart failure. List only commediate Cause (Final sease or condition southing in death)  sequentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last  FEMALE:  B. Was decedent pregnant in the past 12 months?  1 Yes 2 No  9 Unknown  art II. Other significant conditions conditions conditions.	Due to (or as:  Due to (or as:	the death. Do not dee.  The death is a consequence of it.  The death is a consequence	inematory or other ill Mem.  22. Name and A Bruzdzin 1407 Old enter the mode of  CACAC  3 Sctopic preg 5 Other (special e underlying caus	nancy  given in Part I.  26. Place of Dea  Other:  4 \( \) Nursing H	23e. Did tobacc  1 Yes  24a. Was an autopsy performed 1 Yes 2 Id	23d. Date of delimonth  23d. Date of delimonth  2 No 3 Propriet to death? 1 Yes	Maryland  and 21221  Approximate Interval Between Onset and Death  very Day Year  the cause of death?  bably 4 Interval available completion of cause of 2 No
4 □ Donation 5 □ Other (Specify  1. Signature 1 Funeral Service Licens  1. Signature 1 Funeral	b. Due to (or as:  Due to (or	the death. Do not dee.  The death. Do not dee.  a consequence of):	inematory or other ill Mem.  22. Name and A Bruzdzin 1407 Old enter the mode of  CACAC  3 Sctopic preg 5 Other (special e underlying caus	nancy  given in Part I.	23e. Did tobacc  1 Yes  24a. Was an autopsy performed 1 Yes 2 Inthe (Check only one)	23d. Date of delimonth  23d. Date of delimonth  20 use contribute to 2 No 3 Product of death? 1 Yes	Maryland  nd 21221  Approximate Interval Between Onset and Death  very Day Year  the cause of death?  bably 4 Introduced the completion of cause of 2 No

To the Hospital or Attending Physlcian; The law requires that the death certificate be executed attending physician for use as the buria signed by the a page 2 should has been certificate within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SGLARE FRANKLZ 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRZUE

JOHN KOTTARATHZU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear Wilson Dorothy 2009 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Himore Center Square Hospital oseda Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) November 6,1934 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday Months Days Hours 1 □ M 2 □X 219-30-4286 74 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☐ No Rosedale Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 USA 4904 Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse 12 years Manager 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) John O. B. Loetell Dorothy Hillenburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Ridge Road, Rosedale, Maryland Gwynn Lee Wilson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 21 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 5 ☐ Other (Specify) 2009 Baltimore, Maryland 4 □ Donation neral Service Lim 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unseas or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner sician and burial-trans attending physician for use as the burial Physician/Medical sate has been signed by the page 2 should be detached þ Completed after death.

Director; After this certific.
In by the funeral director, I Be Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Expraint activities a cottified at once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Wilson

Part II. Other significant condition	ins contributing to death but not resulting in the underlying caus	e given in Part I.		e contribute to the cause of death?  No 3 Probably 4 Unknown		
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical		26. Place of Death (C	Check only one)			
examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death  1. Natural 5 Pendin 2 Accident investig	(Month, Day, Year) Injury	Injury at Work? 28d	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)			
3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		fice 28f.				
	g Physician: To the best of my knowledge, death occurred at t Examiner: On the basis of examination and/or investigation, in and manner stated.					

29b. Signature and title of certifier

29c. License number 069054 29d. Date signed (Month, Day, Year) 10-20-2009

30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

Square Dr Baltimore, Md 21237 Binh Nauve/ 31. Date filed (Month, Day Year) 9000

Medical

within 24 hours a To the Funeral L completely filled

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 05 PM 5 OCTUBER Debra Lee Whitelock /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Seasons Hospice Randallstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 12, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 55 212-66-9787 Vrs 1954 Pennsylvania Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a.f ehow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f shovevent, tre lifedical Examination is diffied at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Laurel 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20724 United States 3382 Yellow Spring S Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. Specify: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automotive Parts Elementary/Secondary (0-12) College (1-4or 5+) Accounts Receivable 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important; if item 27 is marked othing projury or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) Be Leonard Zeiler Dorothy Manning ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart Whitelock /Husband 3382 Yellow Spring S. Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Narce and Address of Family Funeral Alternatives 21. Signature of Funeral Service Licenses M01442 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ENDOMETRIAL CARCINOMA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burian Physician/Medical as 1 ⊓se 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 📈 No 1 □Yes 2 WNo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire 1 ☐ Yes 2 🐼 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier A 1145931 OCTOBERZI 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT Road Randallstown MD 5401 EDENTEN 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 34040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Year 11,2009 6:25AM Miriam Eleanor West /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Middleburg Brookfield Manor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 8, 1912 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2**X**□ F Maryland 97 Sept. Director <u>213-01-7375</u> Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1 ☐Yes 2 XNo MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21158 3458 Uniontown Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc 1 Tes ANN No. If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 □ Widowed 4 □ Divorced white 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public school 12 school teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Ments tem 27 is marked Mary Baughman 2 Harry B. Fogle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21158 3458 Uniontown Rd. H. Barton West/ Pages 1 iment of Hi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 10/22/09 Sykesville, MD 21. Signature of Funeral Service Licence 22. Name and Address of Facility Hartzler Funeral Home attaina 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off. To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 9 ravice 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 aruco 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARGICAF M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 23 2009 Registrar parket

State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year **Physician** Margretta W. Willard October 21 4:30 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wilson Health Care Center Gaithersburg Montgomery if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | June 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 87 1 □ M 2 🕱 F Yrs Massachusetts 024-18-9526 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wildical Experiment ust be notified at 1 X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 304 Russell Avenue 20877 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ₺ Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary Accounting and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Lewis Wood Dorothy Elder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau Susan W. Smith/Daughter 17100 Hoskinson Road, Poolesville, Maryland 20837 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition October 23 Pages 1 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee M01498 Koy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 힏 in the past 12 mod Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 🖪 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an aw autopsy perform rmed? 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case ref ed to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUSSELL AVENULE 14. ROBERT BIRSCHBACH, MD GAITHERSBURG, NID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1:15 a M oun 2000 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) NIA tonce paltimore Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)
April 6, 1916 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Security Number 6. Sex Days 878 Months 3 1 □ M 2 🔽 🕇 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Nes 2 No Hmore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ № Specify: a Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic tomema 18. Mother's Name (First, Middle, Maiden Surname) 17.,Father's Name (First, Middle, Lagt lovence HON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) alto. MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 □Removal from State 109 tark Other (Specify) 4 Donation 21. Signature of uneral Service Lice 22. Name and Address of Facility MD 2125 Balt. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) theroscleronc diseas Due to (or as a consequence of): Del KIdney himic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hyglene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical ģ Be Completed Medical Certification: To

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/ Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2₩ No 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 27. Manyer of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

00064788

W. MT. ROYAL AVE BATUMPRE MD

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and add ss

32. Registrar's Signature

1600

MD

HARMA

on who completed cause of death (Item 23a) (Type, Print)

within 24 hor To the Fune completely fi

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Eleanor T. Yacovissi **Physician** 7:45 PM 2009 October 19. /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Stella Maris Baltimore Timonium Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 A 89 Yrs. 218-09-0470 April 9,1920 Director MD Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is anaked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Madical Evandres clust be nothing at 1 ☐ Yes XXNo Parkville Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2410 Perring Woods Rd. 21234 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours atter 1 ∐Yes ŽXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 💢 🕏 Specify White þ 3 ₩idowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel A. Miller Nellie Sapp ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2410 Perring Woods Rd. Parkville, MD Kathleen E. Snyder (Daughter) 21234 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Maryland Vets Cemetery 10/26/09 Garrison Forest, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Burgee-Henss-Seitz Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to limine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Due to (or as a consequence of) burlal-Box 68760. attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Legislant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ sign 12608/95 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? The law autopsy performed? certificate 1 ☐ Yes 2 ☐ No I∐Yes Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ag OCTOBER 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

OCTOBER

YACOVISSI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34044 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 7°, 2009ear 5:45 A.M Judith Elaine Adams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 3620 Foxglove Drive Huntingtown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours 01/04/1944 Pennsylvania 184-34-1402 65 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 No MD Calvert Huntingtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 U.S.A. 3620 Foxglove Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Trade Association conference coordinator permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Isaac Ephraim Kessler Doris Effie McKinlev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nicholas A. Adams, Jr., husband <u>3620 Foxglove Drive, Huntingtown, MD 20639</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Metropolitan Crematory 10/08/2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ vears disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day 1 Yes 2 5 2 X No cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 承No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X 1 ☐ Yes 2 ☐ No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 📉 Ño Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

After this certificate has the funeral director, after death. completed filled in by

within 2 To the 1

tospital tel

5 Pending

Investigation 6 Could not be

determined

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D0059061

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. October 7, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road

32. Registrar's Signature

Prince Frederick

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar	State of Ivial	ylallu / L	Certificate of L	neaith and i Death	ivieritai myg	Reg. No.	9	34045	
Physicia	n/	Decedent's Name (First, Middle, La.	,	. D			2. Date of Dear Month		Year	3. Time of Death	
Medic	al	Georg  4a. Facility Name (if not institution, give		t Bue		r Location of Death	September	r 21, 2009		2:30 P M	
Examin	er	5760 Highland Lan			Sunder:		I	1	4c. County of Death  Calvert		
Funeral		Social Security Number 6. S		In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9. Birthplace	e (State or Foreign	
Director		579-48-0101 1 1 Usual Residence of Decedent	1934	Washing	ton, DC						
and show	or	10a. State 10b. County		10c. City, Town or Location						Inside City Limits	
Maryla 8a-f	rect	Maryland Calvert		Sunde	erland					1 ☐ Yes 2 🏌 No	
n the	al Di	10e. Street and Number	•		10f. Zip Code			10g. Citizen of Wi			
th wit ms 23 must	Funeral Director	5760 Highland Lan			20689			United			
or ite		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Eve Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)		<ul> <li>American I</li> <li>White, etc.</li> </ul>	ndian,	
ns afte	ed b	3 X Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates 195	2-1956	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White	e	
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/lan d be fil Mental arked artic ev	မ	Everett Melvin	Buete			Irma	Marie	G1admon			
re, Maryland 1 and 2 should be filed of Health and Mental Hy item 27 is marked oth other traumatic event		19a. Informant's Name/Relationship (7		- 1	Mailing Address (Street			-			
and Heal		Denise L. Cassid 20a. Method of Disposition	y / Daughte		440 Crow Hay	ven Lane,			_	_	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	Disposition (Name of y, crematory or other place		Date	20c. Location - C			
aftin nit. Pa sartme sortan injun	- 3	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service License		MD Vete	22. Name and Addre						
Balti permit. Departi Importa any inju		William B.	Chor		8325 Mt.						
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the cause on each line.	ne death. Do n					Ap	proximate erval Between	
Physician	i	Immediate Cause (Final disease or condition	Resi	sirate	on Ins	ut tie	new			set and Death	
Medical Examiner		resulting in death)	Due to (or as	onsequence o	f): /	0					
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Se din serti	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		· 🗆			23d. Date	of delivery		
<b>BOX</b> death c the attented for u	Completed by Physician/N	in the past 12 months? 1  Yes 2 No	1 ☐ Live Birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		Mont	th Day	y Year	
that the ned by the detache	Phy	9 Unknown  Part II, Other significant conditions of		not resulting in	the underlying cause of	von in Port I	23e. Did tobacco use contribute to the cause of de			-use of death?	
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hysic his ce	၉	1 ☐ Yes 2 ☐ No			patient 3 DOA Oth	er: 4  Nursing H	ome 5 Reside	ence 6 Other	(Specify)		
DIVISION OF VITAL HECONTS, all or Attending Physician: The law requires s after death.  Indicator: After this certificate has been signed in by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director, page 2 should be all by the funeral director.	Certificate:	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of injury (Month, Day, 1	/ear) 28b. Ti	jury work	₹?	28d. Describe ho	w injury occurred	1		
SIO Attender deat cotor:	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	0	- At home, far	M 1 □ m, street, factory, office	Yes 2 □ No	28f. Location (St	reet and Number	or Rural Rou	ute Number.	
DIVI		4 ☐ Homicide determined	building, etc. (	Specify)			City or Town			,	
DIVISION Of VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	/ (Check 2 L Medical Exam	ner: On the basis of exa	mination and/or	eath occured at the time investigation, in my opinio	on, death occurred a	at the time, date an	d place, and due t	to the cause(s		
To the within To the comple	Σ	only one) 3 L Certifying Nu 29b. Signature and title of certifi	se Practioner: To the be	st of my knowle	edge, death occurred at the 29c. License			cause(s) and man			
			too w	<u> </u>	D3	7588		9/23/	109		
2RW 10+1		30. Name and address of person who	completed cause of dea	th (Item 23a) (T	ype, Print)	ere Dr	lushie	Nd 2	065	7	
Stat		31. Date filed (Month, Day, Year)	32. Registra	Signature	6 1		1				
Registra	ir	SEP 2	4 2009 Des	un ,	D. Sparke						

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 20 2009 **Physician** 5:00 Brady Ruth Mary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Huntingtown 3601 Cox Court | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 25, 1925 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Washington DC 84 213-50-9479 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must by tacified at 1 ☐ Yes 2 No Huntingtown Calvert Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 United States 3601 Cox Court Funera 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 ⅓No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white Specify: 1 ☐ Yes 2 ☐ No Specify. ð 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 1 Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) P.G. County Sheriffs Dept. administration permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Thompson W Fields Artis ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5600 Long Beach Dr. St. Leonard, MD 20685 Deborah Ann Charnley - daughter Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 25<sup>Date</sup> 2009 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf Maryland Trinity Memorial Gardens 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acadent-Struke Immediate Cause (Final Acute Extension WREKS Cerebrovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ere brownscular Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Examine Cardiovascular Disease rteriosclerotte Attending Physician: The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 1 Naturel 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 17245 Sterner MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald P SternerOwings MD 20736 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sarke SEP 24 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 34047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year  $P^{M}$ 3:30 Albert Harry BARTLES, SR. October 13, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 5 1923 9. Birthplace (State or Foreign Country)
Maryland 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Railroad 18. Mother's Name (First, Middle, Maiden Surname) Anna Ellen Hamby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 668 Highland Way, Hagerstown, Md. 21740 20c. Location - City or Town, State Date Broadfording Cemetery 10/17/09 Hagerstown, Maryland Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Academi. i de 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 AN 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18019 - rout mo 007 14,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-739-7100 340 MillSt. Hagerstown, MD 21740 DR. VANSANT DATTA

SH-6+1 State

**Division** 

31. Date filed (Month, Day, Year) OCT 14 2009 32. Registrar's Signature

Registrar

neral Director: / filled in by the f

**Physician** 

/Medical

State of Maryland / Department of Health and Mental Hygiene 2 34041 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician EMERY ADDISON COLBERT OCTOBER 1, 2009 10:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12404 LIVINGSTON ROAD FORT WASHINGTON PRINCE GEORGES 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 23 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Year) 1**X** M 2□ F Months 70 Director 577-54-9087 1939 WASHINGTON, DC Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedford Exerciting roughts and Director 1 Yes 2 No MD PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12404 LIVINGSTON ROAD 20744 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 1 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 BOILER PLANT OPERATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fill the and Mental F. 7 is marked oth Be ALLEN THOMAS COLBERT HELEN THERESA STAFFORD COLBERT ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. JEANETTE COLBERT 12404 LIVINGSTON ROAD, FORT WASHINGTON, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BRINSFIELD ELCHOLS CREMATORY 10/9/2009 CHARLOTTE HALL, MARYLAND Signature of Funeral Service tricensee MONTON JOHNSON M00583 THORNTON FUNERAL HOME 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ONE YEAR Immediate Cause (Final LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed burlal-trar resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Physician: The certificate 2 No 1 □Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \sum \) Nursing Home 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation death. 4 hours after death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 24 hours 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) Registrar's Signature State 31. Date filed (Month, Day, Year) 082009 Registrar

# Baltimore, Maryland 21215-0036

	/M	edic
	Exa	ımine
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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		For State Registrar		S	state of	f Mar	yland /	Depa Cer	rtment of tificate of	Health a f <i>Death</i>	and M	ental Hyg	iene g. No.	809	34049	
		Decedent's Name	e (First, Middle	e, Last)								2. Date of Deat Month		Year	3. Time of Death	
Physicia /Medic		lvy Lee	e Dent									October 4			5:27 p <sup>M</sup>	
Examine		4a. Facility Name (I		n, give stre	et and nur	m <i>ber)</i>	aber) 4b. City, Town, or Location of Deat					·				
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Funeral Director		5. Social Security N		6. Sex 1 ☐ M	2 <b>X</b> F	7. Age (	In yrs. last b <b>50</b>	Yrs.	If Under 1 Yea Months Day:		Min.	8. Date of Birth (Month, Day, February		Co	hplace (State or Foreign untry) MD	
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2 should be filed within 72 hours atter death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Evandrer must be notified at	욘	Wilbert 19a. Informant's N		ship (Type.	Print)		19	9b. Mailin	g Address (Stre	et and Numbe	na Bis er or Rura	al Route Number	; City or To	own, State, 2	Zip Code)	
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ss 1 a of He of He rothe		20a. Method of Dis	position				20b. Place	of Dispos	sition (Name of natory or other p		D	Date	20c. Loca	tion - City or	Town, State	
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permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandre must be notified at once.		21. Signature of Fu	uneral Service	Licensee		4			. Name and Add		h.	well Funera	•			
205 29			less U.		wel	l						Prince Fre		MD 20		
			art failure. List	r complicat t only one o	ions that c cause on e	aused the ach line.	e death. D	o not ent	er the mode of d	lying, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death	
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that that the polynomial details	됩	Part II. Other signi	ficant conditi	ons contril	buting to de	eath but r	not resulting	g in the u	nderlying cause	given in Part I	l.	23e. Did to	bacco use	contribute to	o the cause of death?	
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aw rec Is bee 2 shor	Completed											24a. Was a		24b. Were a	utopsy findings available completion of cause of	
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After Uners	ion:	27. Manner of Dear Natural	5 Pendir	ng	28a. Date (Mon	of Injury oth, Day, Y		. Time of Injury		njury at Vork?		28d. Describe h	ow injury o	occurred		
ttend death stor: /	icat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could		200 Plane	of Injury	At home	form etr		Yes 2		28f Location (S	troot and l	Number or Fi	ural Route Number,	
lor A after Direc	Certification: To	4 Homicide	detern	nined	buildi	ing, etc.	(Specify)	iaiii, sti	eet, factory, offic			City or Tow		Valider of 71	urai riodie ivamboi,	
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C										nd manner a lace, and du	as stated. e to the cause(s)				
fo the vithin fo the comple	Mec	29b. Signature and	d title of certifie	er/		1			29c. Lice	ense number	-	2	29d. Date	signed (Mon	th, Day, Year)	
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15		Mar	100 1	Nat	hur		D			Kr	ince	Trede	rick	MD	20678	
Stat		31. Date filed (Mor	nth, Day, Year)	1			s Signature							,		
Registra	ar	OCTO	8 2009	Den	me	A.	Spar	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:11 2009 October Ruth Elizabeth Dunn /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** 12982 Little Hayden Circle Washington County Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 💢 F 1.1924 006-20-9081 85 \$ep. Maine Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 0a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprainer must be notified at 1 ☐ Yes 2 📉 No Directo Maryland Washington County Hagerstown 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 12982 Little Hayden Circle 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward E. Lovejoy, II Ruth E. Lovejoy Weir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14147 Windy Haven Rd. Smithsburg, MD 21783
Date 20c. Location - City or Town, State Diana Harne-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory: 10-6-2009 Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 authin 23a. Part1. Enter the disease, or emplication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 day 50 Physician /Medical resulting in death) Examiner hronce if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): as the burial-tran resulting in death) Last signed by the attending physician d be detached for use as the burial Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Yai autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1**∀**Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been minimal. filled in by the funeral director, completely

> State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

May

31. Date filed (Month, Day

Vy nuly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

23815

29d. Date signed (Month, Day, Year)

Hagerstown, mD 21740.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Margaret Agnes Fraser October 7, 2009 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick If Under 1 Year | If Under 24 Hrs. | 8. Da Calvert County Nursing Cntr Calvert Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 ☐ M 2 🂢 F 79 Director 578-34-9674 4/20/1930 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show a or 28a-f show t be notified at 1 X Yes 2 □ No Director MD Calvert Dunkirk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural"; or Items 23a ury or other traumatic event, the Medical Examiner must b 1243 Prince Street 20754 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own\_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry George Fraser Margaret G. Sheehan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1243 Prince St., Dunkirk, MD 20754 Date 20c. Location - City or Town, State Kathy Dove/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/09 Dunkirk, MD Memorial Gdns. 22. Name and Address of Facility Raymond-Wood F.H., 21. Signature of Suneral Service Licensee PO Box 430, Dunkirk, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MINTIL /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, day leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed Due to (or attending physician a Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year signed by the at d be detached for 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No autopsy performed this certificate 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State

cal

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5801 allentoun Rd; Camp mather, Mano:

31. Date filed (Month, Day, Year) OCT 0 8 2009

29b. Signature and title of certifier

6 Could not be

determined

2 Accident

3□ Suicide

29a, Certifier (Check only one)

4 ☐ Homicide

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygien 2 🔒 👸 9 34052 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 **Physician** 6:44 pm Õ4 Frank Harold Faehner 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville Copper Ridge Nursing Home Carroll. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/05/1939 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Yrs. New York 085-32-7164 Director 69 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Brinklow Maryland Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 420 Brighton Knolls Drive or Items 23a 20862 u.s.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Caucasian naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner Manufacturing Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi Health and Mental H tem 27 is marked ot Frank Eugene Faehner Adelaide Elizabeth Olsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health ar Importent: If item 27 is: any injury or other treus Joy K. Faehner - Spouse 420 Brighton Knolls Dr., Brinklow, MD 20862 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 10/09/2009 Burtonsville, MD \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Emeral Service Licen 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Weeks Sepsis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician an/Medical as the IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Day Year Physici 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dementia 1 Tes 2 No 3 Probably 4 Unknown ted Complet 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 No 1 Yes 2 💢 No 1 TYes Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No P uneral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 XNatural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ) To the Hospitel of within 24 hours at To the Funerel D 1 🔏 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier october 6,2000 .0 D0059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 295 Stoner Ave., Suite 307, Westminster, MD 21157 John Charles Abel, 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 09 2009 Registrar

amend #22 Per TH G897 II/02/09 Jh
State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Fisk William George 08 2009 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CONICO Wastel Hospiceat 1:29 1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/24/1919 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Months Days Hours Min. 1 M 2 □ F 90 119-07-1608 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Wicomico Salisbury Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 924 Winding Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: Army 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: white Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Georgia Winans William Fillmore Fisk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 924 Winding Way, Salisbury, MD 21804 Dorothy Fisk/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)

1st Congregational

Church of Greenwich Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwich, CT 22. Name and Address of Facility Holloway Funeral Home 21. Signature of Fuperal Service Licenses 501 Snow Hill Road Salisbury,Md 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARKINSON Immediate Cause (Final disease or condition resulting in death) ISRASR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes Mo 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence Cher (Specify) 2 ER/Outpatient 3 DOA 20 Ro 1 Inpatient 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 24 hours after death. 72 ☐ Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier 10058410 AVI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1733 Stab Bury up 2 1802 BUF CT 09 Registrar's Signature 31. Date filed (Month,

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 6 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2009 1025 M Belle Elizabeth GREENFIELD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 8. Date of Birth (Month, Day, Y Aug. 12 9. Birthplace (State or Foreign Country) Maryland 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours <sup>(ear)</sup> 1<u>918</u> 1 □ M 2 💢 F Director 91 214-09-8782 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Washington Maryland Hagerstown ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 18024 Putter Drive 21740 items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. id Mental Hygiene. marked other than "natural", or i 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 - 12Clerk Department Store of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be i Paul C. Kretzer Nora Ridenour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Morgan - Cousin 17802 Red Oak Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 10/16/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ cute muocardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a nonsectioner of if any leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte in the past 12 months?
1 Yes 2 No Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier रिंद्र Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl PHY SICIAN 29c. License number CARDIDLOGIST 10/13 2009 6422 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** October 15, 200 9 4c. County of Death 2120 **Elliott** Geatz George /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** raddock Birthplace Country) Date of Birth (Month, Day, Ye. Nov 20, 7. Age (In vrs. last birthday) (State or Foreign 6. Sex Social Security Number **Funeral** Min. Months Hours 1 ☐ M 2 ☐ F 218-30-0315 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show "natural", or items 23a or 28a-f show MD Allegany Cumberland 1 □Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 1039 Longwood Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Korea 14 Bace - American Indian 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □**X**o Specify. Korean 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geatz Restaurant Inc. co-owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman F. Geatz, Sr. Margaret Elliott Geatz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1039 Longwood Avenue Cumberland MD 21502 Marianne Geatz Health if 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SS Peter and Paul Cemetery 10/20/2009 MD Cumberland 22. Name and Address of Facility Parks and Page 1972. Name and Address of Facility Page 1972. Name and Page 1972. Name and Page 1972. Name and Page 1972. Name and Page 1972. Name 197 21. Signature of Fun ral Pervice Lice see 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or con shock, or hear, failural List only beath. Do not enter the mode of dying, such as cardiac or respiratory arrest or complications that Immediate Cause inal disease or condit n resulting in deet VASHIGE **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) signed by the a Ö 9 Unknown of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 1 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 □ No 1 □ Yes 2 1 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖟 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29

State Registrar

DHMH 17 Rev 1/2001

DIC

BISHOP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

WAGONER

OCT

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9

Certificate of Death Reg. No. 34056 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:05 Lawson Haupt OCTOBER 12, 2009 Elvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Reeders Memorial Home Boonsboro BOONSDOLO

If Under 1 Year If Under 24 Hrs. As. Date of Birth (Month), Pay, Dec. 4, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Maryland 85 215-20-8937 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 U.S.A. 8022 Mountain Laurel Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker State Highway Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Haupt Fay Itnyre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Haupt / Son 25425 Oak Drive Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Nation 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/16/2009 Boonsboro Cemetery Boonsboro, Maryland 21. Signature of Funeral Service Licens Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. If ter the disease, or complication or heart failure. List only one Approximate Interval Between Onset and Death ation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cluse on each line. shoo or heart fallu immediat Cause (Final disease or condition resulting in death) 70 THRIVE MONTHS DEMENTIN Y com ADVANCET Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF F 23d. Date of delivery 23b. death Year

**Physician** /Medical **Examiner** 

28a-f show

5

items 23a

should be filed within 72 hours after death ind Mental Hygiene.
marked other than "natural", or items 23

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records.

þ

Be Completed

Certification: To

Medical

9 Unknown

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending

investigation

determined

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1/1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: A
filled in by the fu 24 hours

within 2 To the

State Registrar

EMALE: Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of
1 □Yes 2 □No	4 Pregnant at time of dea

Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Day

1 ☐ Yes

2 No

23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

Hospital:	2 ☐ ER/Outpatient	3 🗆 DO.
	201 701 1	

(Month, Day, Year)

26. Place of Death (Check only one) Other:

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 No

М 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20311 Lappans Road, Boonsboro, MD 21713

04656

29c. License number

301-432-8470

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QADIR GHAZALA 31. Date filed (Month, Day 32. Renistrar's Signature

			1 - State of Mar State Registrar	yland / Depa <i>Cer</i>	artment of F tificate of L	Health and Death	Mental Hyg	iene eg. No. 2009	34057
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Matilda Herche				2. Date of Deat Month	Dav Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea	<u>October</u>	7. 2009 4c. County of Dea	14:18 P <sup>M</sup>
	)		4275 Woodview Lane		Prince F			Calve	
ı	Funeral Director		212-56-0130   1 □ M 2 🗓 F   8	n yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			thplace (State or Foreign ountry) Mania
	show at	ě	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Loc	cation	· · · · · · ·			10d. Inside City Limits
	Maryla 28a-f	rect	Maryland Calvert	Prince F	rederick				1 ☐ Yes 2 🔀 No
	h the	al Di	10e. Street and Number		10f, Zip Code			0g. Citizen of What Co	
	ath with miss 200	<b>Funeral Director</b>	4275 Woodview Lane		20678			Jnited Stat	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates,	If	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🏋 No	n, Mexican, Pue	to Rican, etc.)	14. Race - Ame Black, Whit	
ဂ္ဂ	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup	ation	orking	16b. Kind of Business	
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א ס	iled wi I Hygid other ent, t	Be	17. Father's Name (First, Middle, Last)	THOME I	learth ar		ame (First, Middle, M		earth care
ylar	d be f Menta arked atic ev	ဥ	Daniel Schelski			Karo		Nage1	
Mar	shou h and 7 is m		19a. Informant's Name/Relationship (Type, Print)	4.14				City or Town, State, Zi	· ·
ē,	and and the solution term 2		Elizabeth Herche, daughter 20a. Method of Disposition	42/5 20b. Place of Dispos		Lane, l		ederick, M. 20c. Location - City or	
ē	Page 1 nent of int: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crem Miranda (	natory or other plac			Huntingtown	
Baltimore, Maryland	permit. I Departm Importa any inju once,		21. Signature of Fyneral Service Licensee	22.	. Name and Addres	s of Facility Ra	ausch Fune	eral Home,	P.A.
ш	20 <b>5 8 9</b>	12	William K. Co					ngs, MD 20	736
	Torristani.		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final				c or respiratory arres	st,	Approximate Interval Between Onset and Death
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	Examiner	<u>*</u>	Sequentially list conditions, b.						
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	cate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last c. Due to (or as a co	ensequence of):					
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NICAL L	sian: T ertifica ctor, p		25. Was case referred to medical examiner?		26. Pla	ice of Death (Che	1  Yes 2 eck only one)	No 1 ⊔ Yes	2 🗆 No
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5	nding tth. : After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	ear) 28b. Time of injury	28c. Injury work? M 1 🗆		28d. Describe how	v injury occurred	
10101	r Atter ter dea rector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - building, etc. (S			100 2 2 110		eet and Number or Rui	al Route Number,
5	oital o		9			·	City or Town,	,	
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my Medical Examiner: On the basis of exam only one) 3 Certifying Nurse Practioner: To the best of my	ination and/or investic	gation, in my opiniou	<ol> <li>death occurred</li> </ol>	at the time date and	Inlace and due to the	auea(s) and manner stated
i	To the within to comp	<	29b. Signature and witle of certifier	,	29c. License			d. Date signed (Month	
	1.		Ikons UN loa	M	D5023	3	0	ctober 8,	2009
	KU		30. Name and address of person who completed cause of death Glynis A. Moody, MD, 10845 T			Dunkink	MD 2075		
	State	е	31. O'Chrd (909, 2009) Deneu 32. Registrar's		<u> </u>	DUINTIK	, I'M 2073	1 to 1	
	Registra	r							

			For State Registrar		State of N	naryian	a / Depa Cer	tificate of l	heaith an Death	d Mental Hy	giene Reg. N		3405
	Dharisis	/	1. Decedent's Name	e (First, Middle, La	st)					2. Date of De	ath		3. Time of Death
н	Physicia Medic		Lois	Marjor		kins				Octob	er 5	2009 Year	8:25 P.™
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	land show dat	후	10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits	
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 ☐ Married  4 🏋 Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 If Yes, Give Year or Dates.	? ☐ No	1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No		(Specify Yes or No- uerto Rican, etc.)		14. Race - Ameri Black, White, Specify:	
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Maryland	shour and is m	39	19a. Informant's Na	me/Relationship (7	ype, Print)		19b. Mailin	g Address (Street	and Number o	Rural Route Numbe	er, City o	r Town, State, Zip	Code)
	and 2 Health				rich, daug				Terrace	e, Owings,		20736	
Jor	nt of h		20a. Method of Disp 1 X Burial 2		Removal from Stat	e ce	emetery, crem	sition (Name of atory or other place	· .	Date		ocation - City or T	
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Division	r Atten ter deat rector; by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined	e 28e. Place of In	jury - At hon	ne, farm, stre	M 1 L	Yes 2 No	28f. Location (S City or Tow		d Number or Rura	l Route Number,
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	he Hos in 24 h he Fun pleted	Medical	(Check 2	Medical Exami	sician: To the best o ner: On the basis of se Practioner: To the	examination	and/or investig	gation, in my opinic	on, death occurr	ed at the time, date a	nd place	and due to the ca	use(s) and manner stated.
	To the Newithin 2 To the Complete		29b. Signature and t	itle of certifier	M			29c. License		רע	- 1	te signed (Month,	Day, Year)
			30. Name and addre	ss of person who	completed cause of	death (Item 1	23a) (Tuna D	1 72	0619	7 1	- 1	1 1/3	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 34059 State of Maryland / Department of Health and Mental Hygiene Brandon Jamaal Jones Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month October 5, 2009 1655 hrs **Medical Examiner** Brandon Jamal Jones 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Peninsula Regional Medical Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 7-10-1985 Country) MD 1 X M 216-31-2735 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location an, 10a. State 10b. County 1 X Yes 2 No 28a-f show Wicomico Salisbury MD be filed within 72 hours after death with the Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code notified at U.S.A 21804 530 Hammond Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married Yes Specify:Black 1 Yes 2 X No specify: Widowed Divorced If Yes, Give Year ş 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical ore, MD 21215-0036 ges 1 and 2 should be filed within 7 of Health and Mental Hygiene. "ARCO" Retail Inventory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald R. Jones Terrie Lynn Gregory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21804 503 Hammond Street Terrie Jones/Mother Salisbury, MD 2180 If item 27 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) permit. Pages 1 Department of H 1 X Burial 2 Cremation 3 Removat from State 10-10-2009 Hebron, MD Spring Hill Important: Donation 5 Other Specify 22 Name and Address of Facility 917 W. Isabella St 21. Signature of Funeral Service Licens Bennie Smith Salisbury, MD 21801 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical a. Gunshot Wounds of Torso Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. δ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of death? performed? No Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other: Hospital: 1 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient 1 Yes No 28a. Date of Injury (Month, Dey,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Subject shot Natural FOUND: Yes 2 V No Pending Oct 5, 2009 1620 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) 530 Hammond Street, Salisbury, MD (Specify) backyard determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 6, 2009 O.C.M.E. 317 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

ORIGINAL

ask

32. Registrar's Signature

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State

Registrar

9 2009

31. Date filed (Month Par

State of Maryland / Department of Health and Mental Hygiene 34060 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 10:10P<sup>M</sup> Ralph Korp October 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4550 N. Park Avenue Chevy Chase Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1X M 2 □ F Days Hours 82 Director 542-34-0300 Oct. 13, 1926 Finland Usual Residence of Decedent with the Maryland 3a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits Director 1X Yes 2 □ No |Maryland| Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4550 N. Park Avenue 20815 United States r than "natural", or items 23a filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status /as Deceue... rmed Forces? ☑Yes 2☐No Armed Forces:
1 ⊠Yes 2 □ No
If Yes, Give WWII
Year or Dates: 1945-47 10 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) International Economist Economics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be Korp Monroe 2 Gerda Seeger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Alvada Korp/Spouse 4550 N. Park Avenue; Chevy Chase, MD 20815 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 10/9/09 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, contact failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Parkinson Disease years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 1 ∐Yes 2 X No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) Certification: To Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14+1 MD32864 10/6/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue #1125; Chevy Chase, MD 20815 , M.D. Ari D. Fishman 31. Date filed (Month, Day, Year) Registrar's Signature OCT U9 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Francis Joseph Kushner 5, 2009 6:35 p October | /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 19, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1934 Months Days Hours 1**⊠**M 2□ F 75 Director 203-26-5962 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mardical Examination is ust be notified at 1 ☐ Yes 2 No Carroll Westminster Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 815 Washington Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 ″2 No 1954-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1961 Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Computer Analyst Computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antonette Nevadunskis Joseph Kushner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 Washington Road, Westminster, MD 21157 Alice Kushner, wife 20b. Place of Disposition (Name of South) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Carroll Crematory 10/07/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home Lac 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (10): a consequence of): Stag OW disease or condition resulting in death) /Medical Examiner Lucil as a consequence of): Sequentially list conditions, if any leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Ascutes Due to (or as a consequence of) Box 68760. Physician/Medical for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the detached 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was a... autopsy performed? Yes 2 No certificate 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowl eath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination of the cause (s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one)

WJL 10 NA

State Registrar

29b. Signature and title of certifier

30. Name and address

ho compl

29c. License number

D37949

2 loast home Sut #201

29d. Date signed (Month, Day, Year)

Ct. 6th 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AW Chris Nick Kourtsis, icTo ber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Se: 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 5, 1936 13XX M 2 □ F Months Days Hours Min. West Virginia 73 Director 236-46-6827 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick 1 Yes 2XX No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , 23a c Funeral 6604 Gooseander Court 72 hours after death with 21703 United States 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . or . Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Financial Planner Finance permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nick Courtsis Helen Tsirogotis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris N. Kourtsis, Jr. Son 127 Pittsburg Landing, Charles Town, WV 25414 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature Pineral 9 rvice Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catotcin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the dise shock, of heart failure complications that c. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dorce 4 month disease or condition Medical resulting in death) Due to (or as a consequi-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events and Due to (or as a consequence of): resulting in death) Last burial-1 the attending physician the for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death ☐ Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobaccourse contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only o Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. and address of person who completed cause of death (Item 23a) (Type, Print) 11 min

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:45 A M 2009 Ruby Loraine Leahy Oct. 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Ceci1 Elkton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🗓 F Aug. 8, 1928 81 220-22-3040 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 X No Director Maryland Cecil Conowingo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 148 Johnson Rd. 21918 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White <u>≽</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Walter Taylor Mollie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Leahy/Husband P.O. Box 15, Colora, MD 21917-0015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10-09-2009 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Conowingo Baptist Cemetery Conowingo, Maryland 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service License 111 S. Queen St., Rising Sun, MD ugas 23a. Part 1 Enter the disease or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mores aro Due to (or as a consequence of): 51 S Samuer fields list in Julia sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence)of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 K No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1⊠ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

executed Box 68760 certificate be P.0. Division of Vital Records,

attending physician as the l use signed by the atten Id be detached for u has this certificate To the Hospital or Attending Physician: funeral After death. after death filled in by the within 24 hours a completely

**Funeral** 

Director

28a-f show

ò death with 23a

items.

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"natural"

filed within 72 hours after

12 should be filed w. h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any Injury or other traum once.

Physician

/Medical

Examiner

burial-transit and

Saltimore, Maryland 21215-0036

event, the Medical Examinar must be notified at

31. Date filed (Month, Day, Year) State Registrar OCT 07 2009

29b. Signature and title of certifier

Muhammed A. Niaz, M.D., 151 E. High St., Elkton, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

29c. License number

21921

29d. Date signed (Month, Day, Year)

Amend Item 8 per F.D. 10/08/09 Carroll County, will

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct **Physician** 2009 10:10P <sup>M</sup> Victor Vazquez Lopez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 34B West George St Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 3 729 1081 6. Sex **Funeral** Months Mexico Days Hours Min. 1**X** M 2□ F 28 None Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show MD Carroll Westminster 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 34B West George St Mexico Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Specify: Mexican Maryland 21215-0036 1XIYes 2 ☐ No Specify: Mexican þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Roofer Roofing permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygit Important: If item 27 is marked other if any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Felipe Vazquez Santos Clemencia Lopez Martinez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 34 B W George St. Westminster, MD 21157 Diego Vazquez Lopez-brother Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10-12-200 San Pablo Anicano, 1 X Burial 2 ☐ Cremation 3 X Removal from State Pontion Municipal 4 ☐ Donation 5 ☐ Other (Specify) Mexico 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licenses Thomas D. 254 E. Main St. Westminster, MD 21157 dying, such as cardlac or respiratory arrest, Approximate Interval Between Oriset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the my shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 □ Yes 2 □ № 1 ☐ Yes 2 **N**o To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature nd title of certifier WJL 3 no completed cause of death (Item 23a) (Type, Print) laviohnuto DESTMINSTER, ND ZIST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Of Ma	ryiand / Depa <i>Cer</i>	rtment of H tificate of L	ieaith and iv D <i>eath</i>	ientai Hygie <sub>Reg</sub>	ene 2009	34065
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Med	ical	4a. Facility Name (If not institution, give street and number)	RACE	4b. City. Town, or	Location of Death	October	67 2009 4c. County of Death	
Exami	ner	PENINSULA REGIONAL MENIN	of Center	ے	Alsbury		Wica	
Funera Director		5. Social Security Number 6. Sex 1 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Mrs. Hours Min.	8. Date of Birth (Month, Day, ) 1/29/193	(ea <i>r</i> ) 9. Birtl Con Con	nplace (State or Foreign untry) necticut
yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
e Mar Ba-f sh	Director	Maryland Wicomico	Quantico					1 ☐ Yes 2 🖰 No
vith th		10e. Street and Number		10f. Zip Code			j. Citizen of What Co	untry?
leath v	Funeral	4698 Whitehaven Road  11. Marital Status  12. Was Decedent E	ever in U.S. 13. W	21856	ispanic Origin? (Spe		SA 14. Race - Amer	rican Indian,
iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exercises must be notified at	þ	Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ N	Air Force	Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	Ricán, etc.)	Black, White	ite
72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	during most of worki	ng   16	b. Kind of Business/	ndustry
within tene.	Id III	Elementary/Secondary (0-12) College (1-4or 5-	+) i	O NOT use retired Operat		В	rass Rail	Resturant
illed all Hygi	Be Co	17. Father's Name (First, Middle, Last)	002	<u> </u>	18. Mother's Name	(First, Middle, Ma	iden Surname)	
d y d i y d	To E	Joseph E. St. Lawrence			Cecelia	La Roche	lle	
		19a. Informant's Name/Relationship (Type. Print)  Patricia St.Lawrence/wife					City or Town, State, Z aryland 2	
partition of your permit. Pages 1 and 2 Department of Health almoortant: If item 27 I any injury or other transonce.	ļ	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem St. John	ition (Name of	; .	ate 20	c. Location - City or Trwalk, Cor	Town, State
nit. Pa artmer ortant injury e.		4 ☐ Donation 5 ☐ Other (Specify)  21 Signature of Funeral Service Licensee			- :			
permi Depar Impo		David H. Domago	Ho 50	lloway Fi l Snow H	ss of Facility uneral Ho ill Rd.,	me P.A. Sailsbury	y, Marylan	d 21804
		23a. Part 1. Enter the dise se, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente					Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Upper Go	strointe	stronal	Hemerch	ase	Onset and Death  30 Min
Examiner		Due to (or as a	a con vuence of):					
p ±	ner	Sequentially list conditions, if any, feating to limited at cause. Enter Underlying Cause (Disease or injury that initiated events	t curisaquarice of):					
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ficate be executed physician and sthe burial-transit		3						
tificate ng phy as the	Medical	d						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown		very Day Year				
3, r	by Phy	Part II. Other significant conditions contributing to death but		derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
require een sig	ted t	Type I Dalester pellit	F. brosis			1 ☐ Yes	2 km No 3 □ Pr	obably 4 🗌 Unknown
The law is ate has b	Completed	Type I Diabeter pollit	· · · · · · · · · · · · · · · · · · ·			24a. Was an autopsy performe 1 □ Yes 2	prior to o death?	topsy findings available completion of cause of
VILCI Ilcian: certific ector,	Be	25. Was case referred to medical examiner?		Othe	26. Place of Death	(Check only one)		
Phys er this	. To	27. Manner of Death 28a. Date of Injur	nt 2 ER/Outpatient ry 28b. Time of	28c. Injury Work	4 LI Nursing Ho	me 5 Residen	ce 6 Other (Specinjury occurred	cify)
ath. rr: Afte	atior	1 Matural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	(, Year) Injury		k? Yes 2 □No			
al or Atte s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, stre :. (Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ne Hospit n 24 hour ne Funera	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner sta	examination and/or inv					
Vithi To th	Ň	29b. Signature and title of certifier		29c. License	e number	290	d. Date signed (Monti	n, Day, Year)
CIMP		· All Jino	,	129	1986		10/8/09	
Y"'1		30. Name and address of person who completed cause of de Robert J. Reilly MD 3	eath (Item 23a) (Type, F 560 Rivers d ur's Signature	orint)	1 Salis	bury ma	1. 21801	
St Regist	ate rar	31. Date filed (Month, Day, Year) UCT 0 9 2009 32. Fegistra	ars Signature	ake				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gen 09/21/2009 21:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 01/08/1962 47 Washington, DC 216-58-9952 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at MD Calvert Owings 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or ? r must be n 20736 U.S.A. 1915 5th Street Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Department of Health and Merital Hygiene, important: If Item 27 Is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waste Management Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Williford Bernard Mullen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 5th Street, Owings, MD 20736 Theresa Mullen (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Gdn 09/25/2009 Dunkirk, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee Gary 8125 Southern Maryland Blvd., Owings, MD 20736 Goff J. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner pacrania Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed 133160 sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 XYes 2 No 3 Probably 4 Unknown elevation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an ate has l autopsy performed 25. Was case referred to medical examiner? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO061783 JRW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chang B. Choi, M.D. 100 Hospital Road, Prince Frederick, MD 20678 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 4 2009 ▶ Registrar Jack

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ctobe Clarence Horst Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington County Hagerstown If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Mary Land 8. Date of Birth 7. Age (In vrs. last birthday) 6. Sex 1 X M 2 □ F **Funeral** Days (Month, Day, 213-40-4923 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21742 U.S.A. 21904 Ringgold Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Fannie Horst Martin Lewis S. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte M. Martin-wife 21904 Ringgold Pike Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Reiffi<sup>te</sup>Mennon1 the place) Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 10-14-2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) hows Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nonsequence of) Examin attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Lirector. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 1 🗌 Yes 2 1No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

**⊘***H*−12
State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Mont)

2124

Registrar's Signature

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OCTOBER Walter Manges 16,200 James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MB1 ALLEG. ADDOC Birthplace (Country) MD Date of Birth (Month, Day, Ye Jun 29, (State or Foreign Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** , 1930 Months Days 1 □ M 2 □ F 723-14-7036 79 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show er than "natural", or items 23a or 28a-f show 1 □ Yes 2 □ No Allegany Cumberland MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 10 N. Liberty St. Apt. 301 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1948-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: þ 1948-49 white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Allegany Co. Bd. of teacher/coach permit. Pages 1 and 2 should be filed vegetiment of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Irene Athey Manges Cobern Evans Manges ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 N. Liberty St. Apt. 301 Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) **Margaret Manges** wife 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Oremation 3 □ Removal from State 10/19/20b9 **Davis Memorial Cemetery** MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the dilease, or complication in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1 lure. List inly one pulse on each line.

Immediate Course (First disease or or dridition resulting in that)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** ATT FINE MINVIED /Medical Due to (or as a consequence of): Examiner YEARS CAROLOMY OPATTI SCITEMIC DILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 □ Ves 2 □ No the is been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director; After this villed in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi OCTUSEN 16, 2009 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ann amo JAMES K. MOEN. M.D. 1068 NATIONAL MEHWAY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

5 PH

For State

34069

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Marical Evanir ar must be notified at agnee.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist

	Registrar	Cer	tificate of i	Dealli			Reg. No.					
ian	1. Decedent's Name (First, Middle, Last) Thomas Francis Nairn					2. Date of De Month Septemb	Day	Year <b>2009</b> -	3. Time of Death 3:45 a M			
cal ner	4a. Eacility Name (If not institution, give street and number) 580 Carla Drive		4b. City, Town, or Hunting		of Death		4c. County Calv					
Г	5. Social Security Number 577–52–4877 6. Sex 1 $\underline{\mathbb{N}}$ M 2 $\square$ F 7. Age (In yrs. In $2$	ast birthday) . Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D March	25, 1937	Cour	place (State or Foreigntry) ington, D			
	Usual Residence of Decedent						·	14	Od Jacida City I Imite			
ctor		tingto				10d. Inside City L 1 ∐Yes 2						
al Dire	10e. Street and Number 580 Carla Drive		10f. Zip Code 20639				10g. Citizen of US		ntry?			
Funer	11. Marital Status  1 □ Never Married  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ▼ No	li li	Vas Decedent of H	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)		ce - Americ ck, White,				
þ	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	□Yes 2√√ No	Specify	:		Specif	Whi	te			
ted	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation	et of work	ina	16b. Kind of B					
Be Completed by Funeral Director	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Years	`life. E	lyst	during mos d)	St Of WORK	mg	Public Utility		tric			
To Be C	17. Father's Name (First, Middle, Last) Walter Nairn	_				e (First, Middle t <b>Colli</b>	e, Maiden Surnar • <b>er</b>	ne)				
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Numb	er or Rur	ral Route Numi	ber, City or Town	, State, Zip	Code)			
	Jo Ann Nairn/Wife	580	Carla Di	rive.	Hun	tingtow	n. MD 20	0639_				
	20a. Method of Disposition 20b. P	lace of Dispos	sition (Name of natory or other plac	ce)		Date	20c. Location	- City or To	own, State			
Ы	1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	thern 1	Memorial	Gdn	09/2	29/2009	Dunki	ck, M	aryland			
	21. Signature of Uneral Service Licenses LISA M. Mounts M01516		. Name and Addres		Tee	e Funer Land Bl	al Home vd Owing	Calvers. M	ert P.A. D 20736			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Immediate Cause (Final			Interval Between Onset and Death	_							
	disease or condition resulting in death)  a. Due to (or as a consequence of the control of the c	rence of):	vieg	1013	L CON	H			9 10 gr			
	Sequentially list conditions. b. Heart Transplant									5		
ē	Se uentially list conditions, if any, leading to immediate  Due to (or as a consequence of the conditions)	ience of):		1.00	,							
ä	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ery	my frylly Disease						N DOURS			
EX	resulting in death) Last	ience of):	•	)					7			
n/Medical Examiner	d											
/Me	IF FEMALE: 23c. If yes, outcome of pregnant	ncy _				23d. Date of delivery						
Completed by Physiciar	200, was decement pregnant   1	death 3□ eath 5□	Ectopic pregnand Other (specify)		Month Day			Day Year				
y P	Part II. Other significant conditions contributing to death but not resu	ılting in the ur	nderlying cause giv	en in Part	1.	23e. Did	tobacco use cor	tribute to t	he cause of death?			
g p	hypertension					1 🗆	Yes 21 No	3 ☐ Pro	bably 4 🗌 Unknow	'n		
Sete	huser cholesterales	nia-				24a. Wa	s an 24b.	Were auto	opsy findings available completion of cause of	e		
E O	times Dochalton	4000	<i>p</i> , c			aut per 1 □ Yes	formed?	death?				
l a	25. Was case referred to medical	rece		26. Plac	e of Deat	th (Check only		1 103	2 2 110			
To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	ner: 4 🗆 N	lursing H	ome 5. □Re	sidence 6 🗆 Ot	her (Speci	fy)			
Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Inju Wor	ry at		28d. Describe	how injury occu	rred				
atic	2 Accident investigation			Yes 2	]No							
ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specification)	ome, farm, stro ()	eet, factory, office			28f. Location City or To	(Street and Num own, State)	ber or Rur	al Route Number,			
Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kno and manner stated.	wledge, deatl tion and/or in	h occurred at the to	ime, date a opinion, de	and place eath occu	, and due to the rred at the time	ne cause(s) and r e, date and place	nanner as , and due	stated. to the cause(s)			
Be	29b. Signature and title of certifier		29c. Licens	se number			29d. Date sign	ed (Month,	Day, Year)			
	1 (a Lillman		D 45	235			91	221	09			
	30. Name and address of person who completed cause of death (Item	1 23a) (Type.	Print)				100/01					
	Dr. Catherine I. Brophy M.D. 10			r Bly	zd. I	Dunkirk	. MD 207	754				
ate	31. Date filed (Month, Day, Year) 32. Registrate Signal	ture	have									
rar	SEP 2.4.2009 A	. 191	Rome all									

DHMH 17 Rev 1/2001

			For Amend Items 28a-I per me, g920, 10/12/2011 dhb Certificate of Death	ientai Hyg R	leg. No.	34070						
			Decedent's Name (First, Middle, Last)     Joshua A. Purdue	2. Date of Deat		3. Time of Death						
1	Physicia /Medic			October	1 2009	06:03 ₽M						
1/2	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea							
	Funeral Director		Union Hospital of Cecil County Elkton	0.5.1(5:0.	Cecil							
				8. Date of Birth (Month, Day, Sept. 14	, Year) Co	thplace (State or Foreign Elkton Land						
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
			Maryland Cecil Elkton			1 □ Yes 🏋 No						
036			10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Co	buntry?						
		alD	367 Nottingham Road 21921	I	United Stat	es						
		Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerlo			ncan Indian,						
		by	1 Never Married 2 Married 1  Yes 2 No If Yes, Give 1  Yes 2 No Specify: 1 Yes 2 No Specify:		45.5	Vhite						
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of working tiple. DO NOT use retired)	ing	16b. Kind of Business	Industry						
212	d within giene. rr than " the Me	To Be Com	Elementary/Secondary (0-12) College (1-4or 5+)  8 Disabled		Never En	nploved						
b	2 should be filed and Mental Hygie Is marked other aumatic event, ti		17. Father's Name ( <i>First, Middle, Last</i> )  18. Mother's Name	e (First, Middle, I		1						
<u>ya</u>			Robert Allen Perdue Valery									
Maryland			19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura  19c. The Print of the P			1.11.						
	s 1 and 2 of Health a Item 27 is other tra		Mary E. Ewing / Grandmother 367 Nottingham Road, 20a. Method of Disposition 20b. Place of Disposition (Name of		Mary Land  20c. Location - City or	21921						
Baltimore,	Pages nent of Hant of Hants If Ite		TXBurial 2 Cremation 3 Removal from State North East Methodist	ber /,	•							
莊	it. Pa rtmer rtant: njury				North East, neral Home	Maryland						
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		127 South Main Str	eet, Nor	rth East, M							
		er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death									
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Complications  a. intuitives	him met	hedone	junknown						
	Medical Examiner  b physician and streep burial-transit		Due to (or as a consequence of):									
			Sequentially list conditions, li any, leading to immediate b.  Due to (or as a consequence of).	quence of).								
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.	thyla	OVED BY MEDICAL EXAMINER							
oʻ		Exa	resulting in death) Last  Due to (or as a consequence of):	TON APPROV	ED BY MEDICA							
68760,		edical	dCERTI	FICATION								
_	e as t	Med	IF FEMALE:									
Вох	<ul> <li>The law requires that the death certificate has been signed by the attending I r, page 2 should be detached for use as</li> </ul>	ian/	23b. Was decedent pregnant in the past 12 months?		23d. Date of de Month	Date of delivery Month Day Year						
Division or Vital Records, P.O.		Physician/M	1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown 5 □ Other (specify)									
		by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of death?							
				1 🗆 Y	es 2⊠No 3□P	robably 4 Unknown						
		o Be Completed		24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of						
			25. Was case referred to medical 26. Place of Death	1□ Yes	2XNo 1 ☐ Yes	s 2X No						
	Physician: r this certifica ral director, p		examiner?		lence 6 □Other (Spe	acifu)						
	g Phy ter thi	n: To	27 Manner of Death 28a Date of Injury 28h Time of 28c Injury at		ow injury occurred							
<u>0</u>	i or Attending Physician: The after death. I Director: After this certificate had in by the funeral director, page	atio	2 Accident investigation 09/11/2009 2:00p.m. M 1 Yes 2X No	Subject	ingested d	lrugs						
Divis		Certification:	3 ☐ Suicide 4 ☐ Homicide  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  Found: Residence	Found (Same (Same (Same )) Manor, I	treet and Number or R n, State) 88 Ho Elkton, MD	ural Route Number, Lingsworth						
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier  (Check only one)  (Check only one									
	To the within 2 To the comple		29b. Signature and title of certifier 29c. License number D 5 (7 & 1) 29d. Date signed (Month, Day, Year)									
			New Leting mo D69048		10/0/09							
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  104 Bow Street Elkfun MD 21921									
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	Registr	ar	OCT 07 2009 Sente B. Jake									

State of Maryland / Department of Health and Mental Hydien 2 2 2

			1 - For State Registrar	State of Ma	arylan		artmen rtificat			nd M		ien 2 📳	09	34071	
	Physicia /Medic Examin	4	1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month		Year	3. Time of Death	
			Dorothy Louise Pickett								1 941	7:18 A <sup>M</sup>			
			4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location of	Death	4c. County of Death				
			Carroll Hospice	Dove Hou	se				inste				rrol1	_	
1	Funeral		5. Social Security Number 6. Sex	7. Ag		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birth Cou	place (State or Foreign intry)	
	Director		219-01-9//4	M 28 F	91	Yrs.					9/20/1	918		MD	
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	
	Aaryli r eho	5												1 ☐ Yes 2 No	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleatin and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Machael Examiner must be natified at	Director	MD Carrol1			Woodbir	10f. Zip	Code			1	0g. Citizen o	of What Cou	intry?	
		0	5845 Woodbine Rd.					21797					USA	,	
		Funerai		2. Was Decedent	Ever in U	.S. 13. V	Was Dece			in? (Spe	ecify Yes or No- Rican, etc.)			ican Indian,	
·0		Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 25☐	No					Puerto	Rican, etc.)	В	lack, White	, etc.	
වූ	ours a	þ	<b>¾</b> Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	1 🗌 Yes	2LX.No	Specify:			Spec	ify: Wh	ite	
ည	72 hg	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced	dent's Usu	al Occupa	ition turina most	of worki	na	16b. Kind of	Business/l	ndustry	
7	thin se	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	DO NOT u	se retired)	)	0, 1,0,1,1	9				
7	filed w Hygier Sther th	Co	10			I	Homem	aker				-	Home		
밀	tal H	To Be	17. Father's Name (First, Middle, Last)								(First, Middle, M		ame)		
<u> </u>	should nd Men marke umatic		Roscoe Criswell								e Scheller				
Maryland 21215-0036	h and h and reaum		19a. Informant's Name/Relationship (Typ				-				il Route Number			ip Code)	
ď	1 and Health em 27 ther tr		Jean Condon/Daug	nter	20h F	D84.			e Rd.		odbine,	MD 21 20c. Location		oum State	
5	Pages nent of H ant: If its arry or of		t⊠Burial 2 ☐ Cremation 3 ☐ Re	moval from State	0	emetery, cren	natory or c	other place							
Ħ	t. Pa tmen tant:		4 □ Donation 5 □ Other (Specify)		Mo	rgan Cl	-		-			Woodb			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Eunoral Service License	00		22	Burri	nd Addres er-Qi	s of Facility ueen	Fune	ral Home	e & Cr	emato	ry, P.A.	
			1212 W. Old Liberty Rd., Winfield, MD 21784									D 21784 Approximate			
	The law requires that the death certificate be executed with the death certificate be executed with the the many page 2 should be detached for use as the burial-transit		shock, or heart failure. List only on	e cause on each lir	10.							351,		Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)  a								Week 5				
		e e	Sequentially list conditions, if any, leading to immediate  b. ———————————————————————————————————							-					
		Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a conseq	uence of):									
8760	icate be executed physician and s the burial-transit	dical	d												
89	ntifica ng ph as th	Jed	IF FFMAX F.												
Š Š	eath certific ettending p for use as	an/	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of delivery Month Day Year				
. B	the et ned fo	sici	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown												
<u>0</u>	res that the de signed by the e be detached f	Physician/Me									00- Did t-h				
ŝ	signe bed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribut					
5	w require been si should b	Completed	- Down 12												
ခ္	ne law has t	npi		<del></del>							autops	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of			
		Co									perform	No No	death?	2□No	
of Vital Records,	nysiclan: Th	Be	25. Was case referred to medical examiner?	ospital:				0.5		of Death	ath (Check only one)				
	Phys r this ral dir	1	1 Yes 2 No	1 🔲 Inpatie		ER/Outpatien			4 (   Nui		ome 5 Residence 6 Other (Specify)				
E C	ding F h. After funer	lo l	1 Natural 5 ☐ Pending (Month, Day Year) Injury				Work?			28d. Describe how injury occurred					
<u>s</u>	or Attending Physician: after death Director: After this certification by the funeral director.	ical	2 Accident investigation 3 Suicide 6 Could not be						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Division of	p affig a	Certification:	3 ☐ Suicide 4 ☐ Homicide										1		
	lospital hours a uneral i		29a. Certifier 1 Certifying Phys	cian: To the best	of my kno	wledge, death	occurred	at the tim	e. date and	place.	and due to the ca	ause(s) and	manner as	stated.	
	T 4 IT 7	edical	(Check only 2 Medical Examinations)	er: On the basis of and manner sta	examina	ition and/or inv	vastigation	, in my op	inion, death	h occurr	ed at the time, di	ate and place	e, and due	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1-2.10	1.	4.44	290	c. License		140	4	9d. Date sign			
}	M		<b>)</b>	Xouch				00	0599	73		octb	er 8	, 2009	
J	n		30. Name and address of person who con	npleted cause of d	eath (Iten	п 23а) (Туре,	Print)			2.		4 '	0 /	1,2009 MD21157	
	4)		)ann ( · Agel mo	295	Stol	ner A	R	50	12	501	WS	min	5/5/	M92115/	
	Sta Registr		31. Dayle filed (Month, Day, Year)	32. Registra	ar's Signa	A As	20 1/01	/	•			,	,		

State of Maryland / Department of Health and Mental Hygien 🖁 🛊 🖣 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ROSEN OCTOBE R 08, 2009 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 072-18-2636 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 💢 F Director March 3, 1924 New York, NY 85 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic evant. It a Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Md. Montgomery Potomac Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 U.S.A. 7732 Fontaine by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Libby Kurtzbard Morris Hertz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7732 Fontaine St., Potomac, Md. 20854 Rosen Method of Disposition

20b. Place of Disposition (Name of cemetary, crematory or other place)

A Document of Disposition (Name of Cemetary, crematory or other place)

A Document of Disposition (Name of Cemetary, crematory or other place)

A Document of Disposition (Name of Cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct.12,2009 Jerusalem, Israel \* 4 ☐Donation 5 ☐ Othe) (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fun ral Fervice Linens 254 Carroll St., NW, Washington, DC 20012 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) hed by the a 1 ☐ Yes 2 🛛 No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 21 No 2 100 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 Viursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Mannet of Death 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funaral Completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) D 35436 DLTOBER OS, 2009 I HONTE OSERD, REQUILLE, MD 20852 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

09 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OCTOBER 13, 2009 8:05 A M Mae Routzahn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Washington Boonsboro Reeders Memorial Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
May 9, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🔀 F Months 91 Maryland 217-30-6021 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County if than "natural", or items 23a or 28a-f show the Medical Exeminar is ust be notified at 1X Yes 2 □ No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 U.S.A. 17 Ford Avenue Completed by Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify White 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important; if them 27 is marked other than "ne any injury or other traumatic entering once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beachlev Harvey J. House Mae Elizabeth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Harvey Routzahn / Son 17 Ford Avenue Boonsboro, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/2009 Boonsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MASSIVE STROILE **Physician** 3 DAYS disease or condition resulting in death) /Medical Examiner MEURISMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events burial-tran resulting in death) Last Due to (or as a consequence of). Box 68760, nding physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No been signed by the should be detached Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 13 No 1 ☐Yes 2 ☑ No certificate 1 □Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 🗹 Natural 5 Pending within 24 hours arter vec....
To the Funeral Director: Af investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier mI) 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-432-8470 Lappans Road, Boonsboro, MD21713 20311 GHAZALA QADIR Day, Year) CT 1 4 2009 Registrar's Signature 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene 2019 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** SUSSER October 0 7:08 P 2009 ESHER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 90 Yrs If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □ XF 132-09-5710 June 19, 1919 Brooklyn, NY Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State "natural", or items 23a or 28a-f show idical Examiner must be notified at NJ Middlesex 1 X Yes 2 □ No Highland Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 123 S. Adelaide Ave #2A 08904 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify. White Completed by 3 Widowed 4 □ Divorced nd 2 should be filed within 72 hour alth and Mental Hygiene. 27 is marked other than "natural rr traumatic event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager/ Editor Publishina 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Reiner Solomon Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 slament of Health an Marc Susser 11409 Classical Lane, Silver Spring, Md Department of Health Important: If item 27 any injury or other trong once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery Oct. 9, 2009 Iselin, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral pervious Lic #35 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mon 20012 Approximate Interval Between Onset and Death 12 hours Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 24-48 hours Intercerebral Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): 68760. Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA Division of Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred ospital or Attending hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3 D0068160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly B. Zuzak, MD 8600 Old Georgetown Rd., Bethesda, Md 20814 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 09 OCT Registrar

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State of Maryland / Department of Health and Mental Hygiene

Physician Anna L. Sheppe  2. Date of Death No. Cetober 6, 2009 Year 1:05 a M. 1:05 a M				For State Registrar		, , , , , ,	Ce	rtificate of	Death	Re	g. No. 2009	3401
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Second	1			4a. Facility Name (If not institut	ion, give street and n	umber)		4b. City, Town, o	or Location of Deat	h	4c. County of Death	
Special Content of the Content of	4			Sanctuary at I	loly Cross						Mont	gomery
The content of the		Funeral		5. Social Security Number		7. Age (In yr.				8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign
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Secretary   Secr	ဝှ	z III	ted	15. Deced	ent's Education	1	16a. Dece	dent's Usual Occu	pation	rtring 1	16b. Kind of Business/In	dustry
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Private   Priv	0	it of H			n 3 🗆 Removal from	State 20b.	cemetery, cre	osition (Name of matory or other pla	ce)	Date 2	20c. Location - City or To	own, State
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Physician // Medical Examinor // Medical Exami	ga	ny in		21. Signature of Funeral Servi	ce Licensee	diain	III	Hines-Rinal	di Funeral	Home, Inc.		
Physician Medical Examiner    Physician Medical Examiner		9 9 m m 9		Juliul 1	1. Venuva	14012	41	11800 New E	lampshire A	venue, Silv		
Physician (Medical Examiner    Sequential   Ist conditions   Seque				shock or heart failure. L	or complications that ist only one cause on	caused the de- each line.	ath. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory arre	est,	Interval Between
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Due to (or as a consequence of):    Common   Com				resulting in death)	Due to	(or as a conse	equence of):					
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1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier   29a. Certifier   29a. Certifier   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Signature and didless of person who completed cause of death (Item 23a) (Type, Print)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   32   Penistre's Signature   234   Penistre's Signature	<b>5</b> §	is cer direct	<b>m</b>		Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oti	201			fv)
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Asha Vali, M.D., 9801 Georgia Avenue, Silver Spring, Maryland 20902		12		Jen	eva	UN	4.0		D0052861		October 8,	2009
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Hubert Lee Steward, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 34076

			For State				Cer	tificate	of L	)eath					Reg. N	D		3. Time of Death	
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			Prince Georg					t biath day	Щ,	If Under 1		If Under	24Hrs.	8. Date of	Birth (M	M/DD/YYY	y) 9. B	irthplace (State or	$\neg$
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P.O. Box 68760,	the attending	Physicial	1 Yes 2		Unknown		nant at time of	death 5	Ot	ther (Spec	cify)				_	Ĭ			
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သမ	te ha	Completed														No	1 🗸	Yes 2	No
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/ita	sicial iis cer direct	Be		2 No	Ho	spital: 1	Inpatient 2	✔ ER/Out	atien		OA	Other <sub>4</sub>		ing Home		Residence		Other:	
-f-	g Phy fter the	<u>P</u>	27. Manner of Dea			28a. Da	te of injury nth, Day,Year)	28b. Ti	ne of	Injury		ury at Wo		28d. Des	cribe h	ow injury o	curred		
u :	ottendin death. ctor: A	₫	1 X Natural		ending	-						Yes 2							Law Oiles
isi	r Atte	fica	2 Accident 3 Suicide		nvestigation Could not b	28e P	ace of Injury - A	At home, far	n, stre	eet, factory	, office	building,	etc.	28f. Loca or To	ation (S own, St	treet and N ate)	umber	or Rural Route Num	ber, City
<u>اَ</u>	Division of Vital Records, P.O. B vithe Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification:	4 Homicide		letermined	(Specin													
					g Physicia	n: To the b	est of my know	/ledge, deat	n occi	urred at the	e time,	date and	place, ar	nd due to th	e cause	e(s) and ma	anner as	s stated.	
	To the within To the	Medical	one) 2 💌	Medical	Examiner:	On the bas and manne	is of examination is stated.	on and/or in	estiga					- at the time	, uate a	og J Date	aire and	to the cause(s)	
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			30. Name and ad	dress of pe	rson who c	ompleted c	ause of death (	Item 23a)				21	D = 142	oro MD	2420	1			
			Patricia Ar	ronica-Po	ollak MD	. Assi	stant Medic	al Exami			enn (	orreet,	paitimo	ore, MD	Z 12U				
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	Pag	istra	n (1113)	1 2 11	/UR19	( Del	was po	· PTV											

09-08003 Jennifer Ann Stiens

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 34077

		1- For State Registrar			Certifica	ate of	Death					Reg. No.				
Physic ledical Exan		1. Decedent's Name (First, Middle,Last)  Ann Stiens  2. Date of Dealth Month October 15,						Day 15, 2009			Time of Death 0556 hrs	**				
		4a. Facility Name (if not institu 4627 Priestland Roa		and number)		4	b. City, To Union !		cation of	Death			County of E arroll	)eath		
			6. Sex	7 Age (1	n yrs. last birth	hday)	If Under	1 Year	If Under	24Hrs. 8	8. Date of B	Birth (MM/D	D/YYYY) S	3. Birthp	lace (State or	$\neg$
Funera Directo		5. Social Security Number 219-74-5942	1 M 2	,		Yrs.	Months	Days	Hours		April	30 1	1959 F	oreign Count	try) OH	_
	1	Usual Residence of Decedent 10a. State 10b. Coun		110	c. City, Town	or Locatio	on							1	0d. Inside City Lir	mits
Maryland 28a-f show any	, l	MD Cari	roll		Union									1	Yes 2 X	No
rylan (	턍	10e. Street and Number					10f. Zip (	Code					en of What	Countr	y?	
5-0036 Fed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho	Director	4627 Priest	land Roa	ıd			2	2179	L			USA				]
with 1	ral	11. Marital Status		as Decedent Ev	er in U.S.		s Deceden				cify Yes or N	No-	14. Race - A		n Indian, Black,	
death	Funeral	1 Never Married 2	1		No	1					,	1.	Specify: \	uhit	.0	
after		3 Widowed 4 X	Divorced If Yes, or Date	S	-11) 100		Yes 2			ind of wo	rk done		ind of Busin			
hours	ted	15. Decedent's Education (S Elementary/Secondary (0-1		est grade compi llege (1-4 or 5+		during me	ost of work	ing life. I	DO NOT	use retire	d)		ealth		-	
36 nin 72 e. than '	Completed by	Elementary/Secondary (0-1	2	logo (1 1 or o		regi	stere	ed ni	ırse			110	ear tii	Cai		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	5	17. Father's Name (First, Mid-	dle, Last)								First, Middle	e, Maiden	Surname)			
21 De fi	o Be (		ns								hepp			04-1-	Ti- Code)	
ID 21 should I and Mer	2 2	• 1			1						ral Route N					
<b>≥</b> E G ∃ <b>⊆</b>	anm.	Mrs. Janice La	ane (SIS		20b. Place						Date				own, State	$\neg$
Baltimore, Normit. Pages I and Department of Health	other traumatic	1 Burial 2 X Crema	ntion 3 Re	noval from State	crema	tory or ot	her place)			10-1	6-09	Swl	kesvi	م11	MD	
tim trinent: rtant:	5	4 Donation 5 Other 21. Signature of Funeral Serv			AII										Chape1	$\dashv$
Baltimo permit. Page Department of Important:		Page Haight	Herber	-							ille,				Onaper	
Physicia	_	23a. Part I. Enter the disease	, or complication	s that caused th	e death. Do n	ot enter t	he mode o	f dying,	such as ca	ardiac or	respiratory	arrest, sho	ck, or hear	rt	Approximate Int Between Onset	
'M-cic	al,	failure. List only one ca	Ma	rphine	intoxi	cati	on							13	Death	- 1
, amine	er	or condition resulting in deat		(or as a consec												
		Sequentially list conditions,	b	(or as a consec	neace of).	_										
	a di	if any, leading to immediate cause Enter Underlying Ca (Disease or injury that initiate	ilfier C.													
79	nsit Fxamine	events resulting in death) La	Due to	(or as a consec	uence of):											
Records, P.O. Box 68760, The law requires that the death certificate be executed teate has been signed by the attending physician and	- tran		d	NDED 23a	,27,28	a-f,	permE	, g8	896 I	0/26	/09 T	T				
760, ficate be e	the burial - tra	X UNPENDED		. If yes, outcom-	e of pregnancy							23	d. Date of	delivery		
876 tificat ng ph	as the	23b. Was decedent pregnant past 12 months?	in the	Live birth		2 F	etal death	3	Ectopi	c pregnar	псу		Month	D	ay Yea	ır
Sox 68' leath certifi e attending	iched for use as	1 Yes 2 No 9	Linknown a		me of death	5 0	ther (Spe	cify)				Ť				- 3
. BC he dea	2 18	Part II. Other significant co	"	Unknown	but not resulti	ng in the	underlying	cause	iven in Pa	art I.	23e. D	id tobacco	use contri	bute to	the cause of deat	th?
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<b>'ital</b> Sician	irecto	examiner?	Hospita	al: 1 Inpatier	nt 2 ER/	Outpatier	nt 3 🔲 🛭	OOA	Other,	Nursin	g Home 5	Resid	ence 6 🔽	Other	:: Scene	
Sion of Vital   Attending Physician: r death. ector: After this certif	neral d			8a. Date of Injui	y 28b	. Time of	f Injury		ry at Wor	\	28d. Descr	ibe how in	jury occurr	ed		
OD Con cending	the fur	1 Natural 5	Pending ]	Ed 10.15		1 5:4	7 am	1	Yes 2		unk					
ViSi or Att fter de	Division of Vital Records, P.O. Box 68  To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the formal of the funeral director, page 2 should be detached for use as the following the formal of the formal of the following the formal of the following the follow	2 Accident 3 Suicide 6 X	Investigation Could not be	28e. Place of Inj	ury - At home,	farm, str	eet, factor	, office t	ouilding, e	etc.	28f. Locati	on (Street, vn, State)	and Nymb	eror Ru Prie	ral Route Numbe SCLand I	r, City Rd
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he Hos in 24 h	pletely		ng Physician: T Examiner:On t	ne basis of exar	knowledge, on hination and/o	death occ or investig	urred at th ation, in m	e time, d y opinio	ate and p n, death o	lace, and occurred a	due to the it the time, o	cause(s) a date and p	ind manner lace, and c	as stat due to th	ed. ie cause(s)	
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MJ WJ	4	/	N. 2	$\tilde{\sim}$				O.C	M.E.			00	tober 15	5, 200	9	
++9		30. Name and address of pe	erson who comp	eted cause of d	eath (Item 23a	a)	7									
	Ī	Ling Li, MD Ass	sistant Medic	al Examine	111 Pe	nn Stre	eet, Balt	imore,	MD 21	201						
Po	Sta gistra	(11.	16 2009	32. Registra	's Signature	So	arker	/								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 34071 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 7 oay 2009 Year Doris Eleanor Walz Schoen 2:20 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heritage Harbor Health & Rehab Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Aug 29, 1919 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Min 1 □ M 2 🔀 Hours Mary land Director 212-16-5961 90 Aùq Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits Director Crownsville Maryland Anne Arundel 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21032 1159 St. Srephens Church Road USA items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Marek John Walz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon W. Schoen, son P.O. Box 234, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of Scartely), crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Carroll Crematory 10/08/2009 Winfield, MD 4 Donation 5 Other (Specify) Si ature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a cons if any, leading to immediate cause. Enter Underlying auence of sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ed by the detached Unknown g Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No 2 **N**Nc Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 **N**No ပု 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death.

e Funeral Director: At bleted filled in by the fu Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my coloring double occurred at the time. Medical 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 2009 WJI 10 who completed cause of death (Item 23a) (Type, Print 30. Name and 32. Redistrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 2. Date of Death 3. Time of Death 10:50 PM **Physician** 3 /Medical **Examiner** YKESUILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Security Number (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Months Min. 058-28-4390 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? .5.1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married event, the Medical Exami-1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retirg!) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any injury or other traumatic event, it was any injury or other traumatic event, it was Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 60021 ပ 19b. Mailing Address (Street and Number or Rural Route Number 2527 UNION TOWN AD WEST 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in the art failure. List only one cause on each line. Immediate Cause (Final nerusclerone Cardiovascular **Physician** disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed leral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 □Yes 2 □ No Month Ye ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Onknown 1 ☐ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 2 1NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number WJI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) through 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hober 2009 Kendall Montgomery Stoner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) Mary Land 45 **Director** 216-82-3500 Usual Residence of Decedent show Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturum"

Iny injury or other traummat. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Washington County Hagerstown 10f. Zip Code 10g, Citizen of What Country? Funeral 307 Hollymead Terrace 21742 U.S.A. 12. Was Decedent Ever in U.S. Arged Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 XMarried 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Vinyl Siding & Window Elementary/Seconday (0-12) College (1-4 or 5+) Extruder Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth M. Clark Stoner Stone Kenneth L. Stoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa F. Stoner-wife 307 Hollymead Terrace Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 10-16-2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ResouraT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2420 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed NOW-J that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes / 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes / 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 7 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy perform death? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Lath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Hospitalis

State Registrar

31. Date filed (Mont

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2009

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 13, Sheffer 2009 9:20 Aurelia Wonnie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 217 Weldon Drive Boonsboro Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 218-24-7642 July 16, 1930 Virginia 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 XYes 2 □ No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 217 Weldon Drive 21713 U.S.A. r than "natural", or items 23a the Medical Examiner must be Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lewis Grubb Holly. Sharon Ann 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Weldon Drive Boonsboro, Maryland Victor L. Sheffer / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Cedar Lawn Cemetery 10/15/2009 Hagerstown, Maryland 21. Signature of Poneral Service Acens 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm liate Cause (Final disse or condition resulting in death) eina **Physician** Qat. /Medical Due to (or as a conseque) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending ( IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 € No Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9∏Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an performed? Yes 2 No certificate Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 2 ER/Outpatient 3 DOA 2 1 | Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 the Hospital or Attending 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 Medical Examina and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 2 00056836 ne and address of person who completed cause of death (Item 23a) (Type, Print) 9 Saint Paul Street, Bonslore

State Registrar

24-10

OCT 14 2009 DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Year)

RIMER 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per ME g896 10/21/09 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 34082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** 0.406AM 2009 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAUSBURG PENINSULA REGIONAL Medical ICIMIA 6. Sex. ( 1 M M 2 □ F If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. **Director** Usual Residence of Decedent 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 233 S gwrence Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Arreed Forces? 1 Dives 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 M Married 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ite Magnes." Elementary/Secondary (0-12) College (1-4or 5+) DMMERICA 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1284L 91 AWRENCE DR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chincoteggue 10-13-09 21. Signature of Funeral Service Licensee Home Temperance Ville VA 23442 23a. Ran 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athero Schero **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burlai-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown reare nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably After this certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 □No 1 ☐ Yes 2 54 No 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1X Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

useus

Nicholas

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

ODE

. Registrar's Sigr

WO

Carroll St.

D34593

SAlisbury

19/2/09

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydion 2 0 0

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			1 - For State Registrar	State of Maryland		tificate of i			gienį Reg. Ne		34000
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	/Medi Examir	cal	4a. Facility Name (If not institution, give	street and number)		4b. City. Town. or	r Location of Death	Oct.		0 0 9 c. County of Dea	10:20 <sub>am</sub>
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	Funeral Director		5. Social Security Number 6. S 300-28-3137		birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 1 2 / 0 3 /	th	9. Bi	httplace (State or Foreign ountry) ermany
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
	ith the Marylar or 28a-f show	tor	MD Prince	George's H	yatt	sville					1 ☐ Yes 25€ No
	or 28	Direc	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	ountry?
	s 23e	ral	1903 Wooded C			207				USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Items 23e or 28e-1 show may injury or other traumatic event, the Medical Examinat must be incuffed at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 12 No	ispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	)- 	14. Race - Am Black, Whi Specify: W	te, etc.
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Baltimore,	Pages 1 nent of He ant: If itan		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 14 □ Donationy 5 □ Other (Specified)			sition (Name of natory or other place cake Cre	em. 10/0	8/2009		ocation - City or Beltsv:	
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100	Physician /Medical Examiner		23a. Part1. Enter III disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Breast Countries on the control of the control of the countries of the	not ente	er the mode of dyin	g, such as cardiac	or respiratory a			Approximate Interval Between Onset and Death
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04	26. Place of Deatl				
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Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (: City or Tox			ural Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Medical C	29a. Certifier (Check only one)	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	ige, death and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s date an	s) and manner a id place, and du	s stated, a to the cause(s)
		M	29b. Signature and title of certifier			29c. License			29d. Da	ate signed (Mon	th, Day, Year)
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			For State Registrar	State of Ma	ryland	/ Depa	rtment of H tificate of D	ealth and M eath	ental Hyرا ا	giene 2	009	34084
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	or 28 or noti	ij	10e. Street and Number		Lus	Бу	10f. Zip Code	-		10a. Citizen	of What Cour	
	with t	Funeral Director	1058 Golden West	Way			20657			-	d Stat	
	tems er mi	F.	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. W	as Decedent of His	panic Origin? (Spe	ecify Yes or No-	14. F	Race - Americ	an Indian,
200	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	Armed Forces? 1 ☐ Yes 2 🌠 N If Yes, Give Year or Dates.	0		Yes, specify Cubar  ☐ Yes 2 🏋 No	Specify:	Rican, etc.)		Black, White, or ify: White	
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Baltimore, Maryland 21215-0036	trent crant trant: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(v)	Metro	polita	atory or other place n <b>Crematory</b>	10/02	The second second second		đria, Vi	
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Ī			23a. Part 1. Enter the disease, or company shock, or heart failure. List only o	plications that cause the cause of the cause	he death. [	Do not enter	the mode of dying	, such as cardiac c	or respiratory arr	est,		Approximate Interval Between
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POX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	4 Pregnant at t	☐ Fetal d	leath 3 🔲	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
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_	Hospitz 24 hours Funeral ted filler	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ician: To the best of m ner: On the basis of exa	y knowled	ge, death oo	ccured at the time, gation, in my opinior	date and place, and, death occurred at	d due to the cau the time, date a	use(s) and ma	anner as state due to the car	d. use(s) and manner stated.
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		-	For State Registrar	State o	of Marylar	nd / Depa <i>Cer</i>	irtment of F tificate of L	lealth and N Death	lental Hygi Re	ene g. No. 20	09	34085
	Physicia	n/	1. Decedent's Name (First, Middle, L	•					Date of Death     Month		Year	3. Time of Death
	Medic	al	Doris Gibson Wo		-13				October			14:55 P M
	Examin	er	4a. Facility Name (if not institution, g. 1495 West Mount				4b. City, Town, or Owings	Location of Death		4c. County of		
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9. Birthpla	ace (State or Foreign
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	and show at	ō	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Loc	ation				10	d. Inside City Limits
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چ	ould b nd Mer mark matic		Floyd Gibson  19a. Informant's Name/Relationship	(Type, Print)		10b Mailin	a Addrace (Street	Mary E.	lizabeth	Ward	tata. Zin Ca	nda)
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o.	of He of He If item or othe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3			Place of Dispos	sition (Name of atory or other place	e)	Date 2	0c. Location -	City or Tow	ın, State
gaitimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Spe	ecify)	Sm		e Cemete:		2-2009	Dunkir		
g	permi Depar Impo any ir		21. Signature of Experal Service Licensee  William R. Signature of Experal Service Licensee  8325 Mt. Harmony								-	
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ř	n: The ificate or, pag		25. Was case referred to medical	1			26 Pl	ace of Death (Chec	1 🗆 Yes 2	₩ No 1	Yes 2	! □ No
N I I	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 € No	Hospital:	Inpatient 2	ER/Outpatien	Oth	ar:	ome 5 Residen	ce 6 🗆 Other	r (Specify)	
5	ng Ph fter th ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date	<del></del>	28b. Time of injury	28c. Injun work	y at	28d. Describe how			
SIOL	ttend death stor: A y the fi	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	t be	of Injuny - At h	ome form stre	M 1 L	Yes 2 ☐ No	28f. Location (Stre	not and Mumba	r or Pural E	Pouto Number
DIVISION OF	al or A		4  Homicide determine		ng, etc. (Specif		ot, labiory, diffee		City or Town,		Orribrari	ioute ivanibei,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Exa	miner: On the bas	sis of examination	n and/or invest	gation, in my opinio	, date and place, ar on, death occurred a e time, date and place	the time, date and	place, and due	to the caus	se(s) and manner stated.
	To the vithir comp	2	29b. Signature and title of certifler	// /	111	, morriodge, c	29c. License			d. Date signed		
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	10 Km		30. Name and address of person wh Jonathan Lowenth	1//				ite 310,	Prince F	rodorio	ւ և MT	20678
	Stat	е	31. Date filed (Month, Day, Year)  OCT 0 8 2009	32 F	legistraris Signa	iture	roau, su	Tre DIO,	TITHCE F	r enel TC	111 و ۸۰	20070
	Registra	ır	061 0 0 2009	Lengua	A. A.	acres						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Martin Irenius Wise 2009 34086 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1155 hrs October 5, 2009 **Medical Examiner** Wise. Jr. Irenius Martin 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Calvert Huntingtown 3020 Lowery Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Days Hours Country Maryland Director 01/13/1929 1 X M 2 F 80 218-24-2297 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 Yes 2 Y No Calvert Owings Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be ootfied at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20736 8610 North Solomons Island Road Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married Yes 2 X No If Yes, Give Year 1 Yes 2 X No specify: 4 Divorced 3 X Widowed Specify: white 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) retail grocery 12 district manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irenius Wise Genevieve Mossburg Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven M. Wise, son 618 Lincoln Street, Rockville, MD 20850 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) tant: 10/09/2009 So. Memorial Gardens Dunkirk, MD Donation 5 Other Specify: 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Rausch Funeral Home, constitution of the dear Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr Approximate Interval t e disease, or complicat art I. En er Physician Between Onset and failure. List or ly one cause on each li Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of Other (Specify) 5 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ Yes 2 No 3 Probably 4 ✔ Unknown Valvular Heart Disease; Atrial Fibrillation Completed page 2 should 24b. Were autopsy findings available 24a. Was an been prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 No 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA After this မ 1 V Yes No funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No hours after death. Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined 24 hours a 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b O.C.M.E. October 6, 2009 me and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

3 State

32. Registrar's Signature ark

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 2, per Phy. 10/08/09 Carroll Co., will
State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar 34087 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sep MARIE WILDER **Physician** FRANCES 200 1 M 25 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2√2 F Director 87 Sept 27, 1921 215-16-0187 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at Director 1√⊋Yes 2 ☐ No MD Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6336 Cedar Lane 21044 USA Funeral items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married o, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ≥ Specify: White 3 XWidowed 4 ☐ Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Howard County Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other tha any Injury or other traumatic event Board of Education Cafeteria Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Nardo ဂ Josephine DeFina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Panther Drive Hanover, PA Bill Wilder/son 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park 9/30/2009 Elkridge, MD 21. Signature of Funeral Service Licenses Prints of the Print of the P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician bue to (or as a consequence of)! 30 minutes disease or condition resulting in death) /Medical Examiner CECONATY CETTERY disease 5 years Sequentially list conditions Examiner If any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No ģ Year Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The performe Division of Vital 1 □Yes 2 No 2**X**No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL 2009 Sep. 25 125004 ella 5755 Cedar Lane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HO SF HOWARD KU CK Ca GOW COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artment of F rtificate of	lealth a <i>Death</i>	ind Ment	al Hygie Reg	ene 2009	34088
Dhusisi		1. Decedent's Name (First, Middle	, Last)						ate of Death	Day Year	3. Time of Death
Physici /Medic		Julia	Hester			Willey	7	IV.	10 -	8 - 09	22:30
Examin		4a Facility Name (If not institution	give street and number	) ,		4b. City, Town, o	Location of	Death		4c. County of Dear	
		Coastal Hospic		Lak		Salls	bury			Wicomi	
Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 🏝 F		last birthday)	If Under 1 Year Months Days	If Under 2	Min. (M	te of Birth onth, Day, Y	(ear) 9. Birt	thplace (State or Foreign ountry)
Director		218-16-9093	10 W 243;	8:	3 Yrs.			Aug	ust 14	,1926 Mar	cyland
MC T		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation		-			10d. Inside City Limits
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23a or 28a-f show ast be rotified at	rec	MD Wicom:	LCO	1. 1	Parson	10f. Zip Code			100	. Citizen of What Co	j
3a or	Ö	33464 Wango Ro	na d			218	2/19			USA	•
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arc	မ	William		Li	ttleto		Ruth				Tingle
any Injury or other traumatic event, the Medical Ex- once.		19a. Informant's Name/Relationsh								City or Town, State, 2	Zip Code)
		William Willey-	- Husband	l ook B		4 Wango F					T- Chat
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	ted by		is contributing to death i	but not rest	aiting in the or		enin Faiti.		1 ☐ Yes	0	robably 4 Unknown
	Completed							24	4a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
		25. Was case referred to medical							□Yes ≥	ZHYō 1 ☐ Yes	; 2 □ No
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1	Me	29b. Signature and title of certifier				29c. Licens	e number		29d	I. Date signed (Mont	h, Day, Year)
		1/1			- A*	A	0058	1410		10-09-	-09
		30. Name and address of person v	ho completed cause of	death (Item	23a) (Type,	Print)				0 (4)	
Ci	ta	31. Date filed (Month Day Year)	32. Redist	trar's Signal	1/3	SKUS	un	7	urp	2180	
Sta Registr		OCT 0	2009 Sen	ma	A. A	barry		-			

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	edica mine		4a. Facility Name (if not institution, 9083 Dawn Court		number)			4b. City, To		Location of				. County o	f Death ederic		
Fune Direct				6. Sex 1 ☐ M 2 🔀		(In yrs. last i 82	birthday) Yrs.	If Under 1 Months [		If Under 2 Hours		8. Date of Birt Month, Da March 4,		7	9. Birthp Count Mary	lace (State on) Land	or Foreign
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death with items 23		Funer	11. Marital Status	Armed	Forces?		13. V	Vas Deceden Yes, specify	it of His	spanic Orig	in? (Spe	cify Yes or No-		14. Race	America	an Indian,	
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YIANG Z Id be filed wi Mental Hygic arked other		ωŀ	17. Father's Name (First, Middle, La Guy V. Burkett	ust)				. Tomerica	-	18. Mother	r's Name Esthe	(First, Middle, r Florie	Maiden	Surname)			
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Dallinor  permit. Page 1  Department of Important; If it in injury or	once.	ł	4 Donation 5 Other (Scale)  21. Signature of Funeral Service D	pecify) censee		M014						uneral He Frederic					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Ohyacicism/Mo	iysician/i	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	4 □ P	outcome of ive Birth 2 regnant at t nknown	f pregnancy  Gretal detime of deat		Ectopic pred Other (spec		,				23d. Date Mont		,	Year
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Physic Physic this ce	2	2	1  Yes 2 No		☐ Inpatien		Outpatien	3 DOA	Other	4 ⊔ Nur		me 5 Resid					
eath. or: After	Cortificato	Call	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n	ation (N	onth, Day,	Year)	injury	М	work?	/es 2 □ 1		edi. Describe II	OW IIIJUI	y occurred			
tal or Att its after d al Direct	- Ind		4 Homicide determine	28e. Pla	ace of Injury ilding, etc. (	y - At home, (S <i>p</i> ec <i>ify)</i>	, farm, stre	et, factory, or	ffice		2	28f. Location (S City or Tow			or Rural i	Route Numb	per,
To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Modical		29a. Certifier 1 Certifying (Check 2 Medical Exonly one) 3 Certifying	aminer: On the	basis of exa	mination an	d/or investi	gation, in my	opinion	n, death occ	curred at	the time, date a	nd place	, and due to	the cau	se(s) and ma	nner stated.
No William		-	29b. Signature and title of certifier		N	N	1D	29c. Li	icense i	number 339	1		29d. Da	te signed (I	Month, D	ay, Year)	
		_	30. Name and address of person w	1/2	12,1	ath (Item 23:	80	Tol	H	ous	RA	re,	Fu	dei	iel	1, MI	)
Regi	State strar	20	31. Ďaté filed (Month, Day, Year)  OCT 2.3	2009	. Redistrar's	s Signature	1. 1	and	,			,				217	201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34090 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Ve.lma Rosalie Young Kober 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F March 4 219-20-1194 Maryland Director 83 Usual Residence of Decedent should be filed within 72 now. - and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show in marked other than "natural", or items 24 or 28a-f show in event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Washington Boonsboro 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6509 Gilardi Road 21713 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married ρ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carley Smith Erma Nicodemus permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6509 Gilardi Road Boonsboro, Maryland Dean R. Young / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/14/2009 | Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Fineral Strvice Licensee BastreStattferFarTuneral Home, P.A. 7606 Old National Pike Boonsboro, Maryland 21713 23a. Part . Enter the disease, or complications shock, or heart failure. List only one cause aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final assisportmonery assest-Physician/ disease or condition his Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ng physician and as the bunal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that A hours after death. The there are the contributed the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the bunal-transit Hyponatremia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical acidosis Metabolic Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown vascular biscase 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 29b. Signature and title of 29c. License number 744996

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Later Mack Mp. 2031/ Lappan, Rd Boonston MD 21713

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 8 Day 2009 7:25 Francis Brandfield Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick 1321 Taney Avenue Frederick Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Maryland 1 X M 2 □ F Days August 17 Hours 216-22-9582 78 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21701 United States 1321 Taney Avenue 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married "natural", or þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. Vietnam 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Operations Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Austin Ulysses Young, Sr. Irene Sheets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ingeborg J. Young / Wife Taney Avenue, Frederick, Maryland 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12, 1 X Burial 2 Cremation 3 Removal from State October any injury or Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 22. Name and Address of Facility Keeney and Basford PA Funeral Home, 106 East Church St. Frederick, Maryland 21701 21. Signature of Funeral Service Licensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between nset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) WEP K Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Dav Pregnant at time of death the the 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Dioibetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an pertenson page 2 s prior to completion of cause of death?
1 ☐ Yes 2 ☒ No \_\_\_\_\_\_ autopsy this certificate 2. No Division of Vital director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D51643

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State Registrar 31. Date filed (Month, De

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 25, 2009 Burley H. Alt. 6:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours 1071971931 West Virginia 78 Yrs **Director** 233-50-3051 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218 Earls Road 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Manufacturer Line Worker 4 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Alt May Vanmeter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Mitchell (Daughter) 5A Springhead Court, Cockeysville, Maryland 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 10/29/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice <sup>22. Name and</sup> Bruzdzīnski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, of heart failt Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) OLUN Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on that the death cert ficate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Yes 1 ☐ Yes 2 ☐ Unknown Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accider iniury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the i Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

State Registrar

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29a. Certifie

(Check only one 29b. Signature and fit

TUNES

31. Date filed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

YRD TIMUNIUM MD

State of Maryland / Department of Health and Mental Hygiens 19 34093 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 7:35 am Benjamin 22, Barrett Oct. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 2808 Glenisle Road Riva If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 216-30-4493 73 Director 03/10/1936 Maryland Usual Residence of Decedent tiled within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Examinat must be notified at MD **Funeral Director** Anne Arundel Riva 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2808 GlenIsle Road 21140 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Amed Porces? 1 XYes 2 No If Yes, Give Marine Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Electrician Electrical permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Barrett Ellen Dotson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Barrett/Wife 2808 Glen Isle Road, Riva, MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Cremation Services 10/23/2009 Havover, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services Zama C. Hardest 7522 Connelley Drive, Ste.N, Hanover, MD 21076 M01197 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Loophageal carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred I Director: After to in by the funeral Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated title of certifier completed cause of death (Item 23a) (Type, Print) person wit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

State

COPPER KIDGE

Registrar's Signature

,710 Obrecht Road, Sykesville, Haryland 21784

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month I O 22 Day 2009 Gertrude E. Boddie 2:02p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Towson Gilchrist Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 220-22-8557 86 2-10-1923 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Baltimore MD N/A 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 1605 Lochwood Road 21218 U S 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Black 1 ☐ Yes 2 🛣No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event at a the action. Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Mercy Hospital Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Daniel Chancey Lucus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD 20721 Gary Harrison -Nephew 11314 Dundee Drive Baltimoré, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Nat'l Memorial10-29-2009 Laurel, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses la 1101 E. North Avenue BALTO, MD 21202 Ŋ wa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UBDURAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** montas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence dy attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be et 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnate 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes cate has been signated by page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 2 🗌 No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending 2 Accident
3 Suicide KIST 8 2009 Fell at home 1 Yes 2 No UNKABUM Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined BALTIMICE, MI) 1605 LOCHWOOD RO home Medical 1. Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number OCTOBER 22 ZOO9

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

6701 N. Chaples ST

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES MO

2009

26

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34091 Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Lorraine Margaret Battle 1245 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltmore N/ABalhmore (ih sinai 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 220-20-3394 1 □ M 2 F Months Days Hours Min. 82 Maryland 22, 1927 Sept. Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 2811 Edgecomb Circle N. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Provident Hospital Switchboard Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Dyson Joseph Stanley 19a. Informant's Name/Relationship (Type. Print)
George Micheal Hill/ 19b Mailing Address (Street and Number or Rural Route Number City of Jawa State Zip Mary land 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11<sup>D</sup>/12/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Operal Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 24a. Part 1 Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Compications Cordnan disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Milletry 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown Chroni YUCHU 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy pertension perforn 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1☐Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

Examiner The law requires that the death certificate be execuand burial-trar Box 68760 attending physician the as nse o P.0. the à signed i of Vital Records, has page 2 s certificate Hospital or Attending Physiclan: 7 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p Division within 24 hours after
To the Funeral Directory
Completely filled in by

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be

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Physician/Medical

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Completed

Be

Medical Certification; To

29a. Certifier (Check only

**Funeral** 

Director

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

and Mental Hygi

permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau

**Physician** 

/Medical

ould be f

with the Maryland

Baltimore, Maryland 21215-0036

27. Manner of Death

6 ☐ Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D50693

tUSPI PAL

29d. Date signed (Month, Day, Year) October 22, 2007

Registrar

MUDEN h. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

NW

To the

State of Maryland / Department of Health and Mental Hygien 34097 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Boehk 2009 22:42 October Kathesine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Honkins Hospita timure John N/A Birthplace (State or Foreign Country) 6. Sex Year Date of Birth (Month, Day, Year) 5. Social Security Number 7 Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🕱 F Months Days Hours Director 11/22/1957 MARYLAND 216-72-5863 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code and 2 should be filed within 72 hours after death with USA Funeral 2609 MEADOWLAND COURT 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 【 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 9 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) COASTAR GROUP RESEARCH ANALYST 2 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Menta item 27 is marked 2 CHARLES E. FRAIM, SR MARY RITA DIETRICH 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY BOEHK/HUSBAND 2609 MEADOWLAND COURT BALTIMORE, MD permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **METRO** 10/27/2009 CREMATORY, INC. CATONSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO1139 Jear U 8521 LOCH RAVEN BLVD. TOWSON. MD Approximate Interval Between Onset and Death 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ulmonary hyperension disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading a lumine date cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a nonsequence of or Attending Physiclan: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 X No 1 Nes 2 No 1 🗆 Yes **Director**: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title RES-000 Cktoby P005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Minder Camille 600 N. WOLFE STREET BALTIMORE. 31. Date filed (Month, Day, OCT 26 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per Fh G897 11/2/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22, 7 Year 2104 Och her **Physician** Sr. Bradley Edward Andrew /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner en Baltimore Washington Medical Center Anna Surnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. Dec. 31 5. Social Security Number **7636** 217-09-7336 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 ☑ M 2 ☐ F 91 1917 TΑ Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Odenton Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 filed within 72 hours after death with USA 21113 items 23a 1010 Samantha Lane #201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married o, Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced "natural", Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Western Union 12 Lineman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Bradley Margaret 2 Joseph **Bradley** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If item 27 is any Injury or other trau 1010 Samantha Lane #201, Odenton, MD 21113 Marie H. Bradley (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 28 Maryland Veterans Cem Crownsville, Maryland 4 Donation 5 DOther (Specify) 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licen de Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. 23a. Part 1. Enter the disease, o shock, or hear failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) means **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): 68760, Physician/Medical signed by the at ending p d be detached for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 🗌 Unknown 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No Vital 1 □Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jospital D.
4 hours after dec.
-reral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr-1 6 July 30 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 34099 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician BRUCE 7:56 AM 2009 'Au l 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hopkins Hospital Johns If Under 1 Year If Under 24 Hrs. North Days Hours Min. Dec. 5,1981 7. Age (In yrs. last birthday)

27 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □**X**M 2 □ F Maryland Director 213-23-2939 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 12 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanting must be notified at MD 1 X Yes 2 □ No Director Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 707 S. President Street 21202 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🐼 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) District Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Bruce Sharon Rose Hubscher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trat once. Stacey Petzold/ Sister 9302 Georgia Belle Dr. Perry Hall, MD 21128 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) October 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Odenton, MD West Arundel Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu e d Funeral Service Licensee 22. Name and Address of Facility Rendon-Bailey Funeral Home, P.A. rak /M01452 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final **Physician** Die to (or as a consequence of): disease or condition resulting in death) /Medical Examiner leukemia myelogenous Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2√No 24a. Was an has certificate 1 ☐ Yes r this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 Natural
2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/25/2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21287 600 N Wolfe Street TRAN NAUI Registrar's Signature 31. Date filed (Month, Day, Year) 32 State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **CManth** 20 Med 5:27 p Stephen James Birckhead, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Gilchrist Hospice Towson Social Security Number Sex 1- M 2 - F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. Offenth, Dayz Year 924 Gountal Vland 218-14-5960 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Reisterstown 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21136 U.S.A. 111 Danbury Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 1 Yes, 2 1946 Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Photo Compositer Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elisa Louisa Kalbskopf ပ John Thurman Birckhead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Danbury Rd. Reisterstown, MD. 21136 Kathryn Birckhead - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cem. Oct. 26,2009 Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lcknard Tuneral Chapel P.A. 21. Signature of Funeral Service Licenses Hart Elles 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) s a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed signed by the attending physician and does detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Be

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires after death.

Director: After this certificate has Factor and Comment of the contract of the c within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

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Certificate:

Medical

25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 6 Other (Specify) WOSPLE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injuly occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 □ Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year)

Ochoser 22 2009

ess of person who completed cause of death (Item 23a) (Type, Print)

mound

ANZLES MO unles 6701 N. ( 31. Date filed (Month 32. Registrar's Signature

State Registrar

			For State	State of Maryland / De				0000	21 101
			Registrar	C	ertificate of Death		Reg. N	<u>2009</u>	34101
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2				ay Year	3. Time of Death
	Medic	al	Francis (	Docek	1		10 2		1752 M
	Examin	er	4a. Facility Name (if not institution, give st		4b. City, Town, or Location		4	c. County of Death	53.04
	Europel		Johns Hapkins P 5, Social Security Number 6, Sex	7. Age (In yrs. last birthda)	If Under 1 Year If Und		Date of Birth		lace (State or Foreign
	Funeral Director			M 2 □ F 90 Yrs.	Months Days Houn	rs Min. (	(Month, Day, Year)	919 Count	yland
			Usual Residence of Decedent					717, 1242	7
	sho sho dat	ğ	10a. State 10b. County	10c. City, Town or	_ocation			11	Od. Inside City Limits
	Mary 28a-1 otifie	<u>  is</u>	Maryland Balti	more	Edgemere	e			1 🗌 Yes 2 🛣 No
	h the kaor ben	[윤]	10e. Street and Number		10f. Zip Code			Citizen of What Coun	,
	h wit ns 23 nust	Funeral Director	6510 North Point		!	21219		ited Stat	
	deat riter iner		THE WALLES	2. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mexic</li> </ol>	Origin? (Specify ican, Puerto Rica	Yes or No- ın, etc.)	14. Race - America Black, White, 6	
21215-0036	al", o	d by	1 ☐ Never Married 2 ☐ Married  XXX Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII	1 ☐ Yes 2 💢 No Spec	cify:		Specify:	White
9	atura ical E	Completed	15. Decedent's Edu		edent's Usual Occupation	-	16b.	Kind of Business Inc	
215	n 72 l an "r Med		(Specify only highest grade Elementary/Seconday (0-12)		e kind of work done during m DO NOT use retired)	most of working	113		,
21	withii giene er th the		8 Years	- · · · · · · · · · · · · · · · · · · ·	ne Electrical	Foreman	1	Steel In	dustry
pu	filed al Hy d oth	Be C	17. Father's Name (First, Middle, Last)		18. Mo		rst, Middle, Maidei	n Surname)	
yla	id be Ment arke	욘	Michael Bocek			Agnes G	Gier		
Maryland	shou and is m raum		19a. Informant's Name/Relationship (Type Mr. Francis Bocek,		iling Address (Street and Nur 27 Salisbury A			or Town, State, Zip C Maryland	
6)	and 2 Health		20a. Method of Disposition		<u> </u>				*
Baltimore,	ge 1 art of h		1XXBurial 2 ☐ Cremation 3 ☐ R	emoval from State cemetery, c	position (Name of ematory or other place)	Date		Location - City or To	
ΞĦ	it. Pa rtmer rtant njury		4 Donation 5 Other (Specify)		sary Cemetery			ltimore,	
Bal	perm Depa Impo any i	. 9	21. Signaturi Funeral Service Licenses		22. Name and Address of Fa Duda-Ruck Fur	neral Ho	me of I	oundalk, I	nc.
			23a. Part 1. Enter the disease, or complic	eations that caused the death. Do not e	7922 Wise Av			ryland 21	Approximate
٠,	death certificate be executed    Continuous   Continuous		shock, or heart failure. Liet only one Immediate Cause (Final	cause on each line.	, ,				Interval Between Onset and Death
			disease or condition resulting in death)	Due to (or as a consequence of):					
	,			11 TI				1	18h-5
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	1.00	- V			1,1,2
d.	d ansit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events	Chronic Su	orapubic Co	atheter			ears
170	exectan an an rial-tr	<u> </u>	resulting in death) Last	Due to (or as a consequence of):					
9	te be nysici he bu	dical	d						
687	rtifica ing pl	ğ	IF FEMALE:						
×	th ce ttend or us	ian,	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of delive Month	ry Day Year
Box	e dea the a hed f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Unknown	Other (specify)			***************************************	,
P.O.	nat th ed by detac		Part II. Other significant conditions con	ributing to death but not resulting in th	e underlying cause given in P	Part I.	23e. Did tobacco	use contribute to th	e cause of death?
S, F	ires t sign	d b					1 🗆 Yes	2 No 3 □ Prob	ably 4 🗆 Unknown
ord	requiper shoul	lete					24a. Was an	24b. Were autop	sy findings available
ec	ne law e has age 2	Completed by					autopsy performed?	death?	npletion of cause of
E H	an; Th tificat tor, pa	Be C	25. Was case referred to medical		26. Place of D	Death (Check only	1 ☐ Yes 2 🙀 I	No 1 L Yes	2 🗀 NO
Viti	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 📉 No	spital:	ient 3 DOA Other: 4 D	Nursing Home	5 Residence	6 Other (Specify)	
of	ng Ph ter th neral		27. Manner of Death  1   → Natural 5   → Pending	28a. Date of injury 28b. Time (Month, Day, Year) injury	of 28c. Injury at		Describe how inju		
on	eath. or: Af the fu	lica	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Yes 2	2 🗆 No 💹	56		
Division	or Att fter d irect n by i	Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		Location (Street a City or Town, Star	and Number or Rural te)	Route Number,
	pital ours a sral Deral Cilled		29a. Certifier 1 Certifying Physic	ian: To the best of my knowledge, dea	h easyward at the time, date a	and place and du	us to the serves(s)	and manner as state	4
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	(Check 2 Medical Examine	r: On the basis of examination and/or inv Practioner: To the best of my knowledge	estigation, in my opinion, death	th occurred at the	time, date and place	ce, and due to the cau	se(s) and manner stated.
	vithin To the	2	29b. Signature and title of certifier	Tradicinos in an post of my knowledge	29c. License number			ate signed (Month, L	
	,		Jonil A Ja	may Medical Doc	or RES-0	000	١	0/21/20	109
	100		30. Name and address of person who cor				4940 E	astem A	re
	10,		Jemilat Badgn	nas Johns Hopkir	s Bayview Me	ed Ctr.	Boutin	ore, MD	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1				
	Registra	ar	OCT 26 20	B / Temp	hadel.				

DHMH 17 Rev 7/2009

Amend 19a, per FH G896 10/26/09 TT Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Octoner 1002 pM 20 2009 Brewn /Medical William 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/08/1924 5. Social Security Number **Funeral** 1 X M 2 ☐ F 84 Yrs. MD 218-14-0125 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ehov eny injury or other treumatic event, the Modical Examinar must be notified at MD BALTIMORE OWINGS MILLS 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 10216 CASCADE FALLS COURT 21117 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2X No Specify: Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES MANAGER TRUCKING 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **BRAWN ZITNER JACOB** 19a. Informant's Name/Relationship (Type, Print)
PATRICIA SELT / COMPANION 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10216 CASCADE FALLS CT., OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State BNAI ISRAEL CEMETERY 10/23/2009 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Phulmenia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last resolve and positive Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use es the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ို this within 24 hours atter death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Naturai 5 Pending investigation 1 Yes 2 No М 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 129085 Octobe 20 30. Name and address aperson who completed cause of death (Item 23a) (Type, Print) OW COUNT raca Ja

State Registrar nllon

31. Date filed (Month, Day, Year)

26 2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Ray strar's Signature

			For State Registrar	State of Maryland /	Department of Health and M Certificate of Death	Mental Hygie	711114	34103
10.36	Physici /Medio Examir	af	1. Decedent's Name (First, Middle, La	ee Cornis ve street and number)	4b. City, Town, or Location of Death	OCTOBER	4c. County of Death	3. Time of Death  26:22A
	Funeral Director works	or		Sex 7. Age (In yrs. last t	1 00 77 4	8. Date of Birth (Month, Day, Ye	ear) 9. Birthp	olace (State or Foreign
91	72 hours after death with the Maryland natural", or items 23a or 28a-f show filest Examinat he notified at	/ Funeral Director	10e. Street and Number  58 7 615  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Porces?  1 12 Yes 2 No If Yes, Give	10f. Zip Code  2 2 5  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		Citizen of What Coun	atry?
Ind 2121	be filed within 72 hours after dea ntal Hygiene. ed other than "natural", or items event, Ite Medical Examinat in	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)  17. Eather's Name (First, Middle, Las	Year or Dates: ducation 16 ade completed)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b	b. Kind of Business/Inc	ack dustry
, Marylan	nd 2 should alth and Mer 27 is marke r traumatic	To Be	Dough Lass 19a, Informant Name/Relationship Brenda CO	Cornesh	So Douth 1 3b. Mailing Address (Street and Number or Aug 5817 GIST Avenue	1 Mae	ual ual	Ker Code) ZIZI Savo
altimore	permit. Pages 1 ar Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	of Disposition (Name of ery, crematory or other place)  2500 + 0Ves 10 - 2  22. Name and Address of Facility	Date 200 27-2009 O	wire Mi	wn, State arylard alservico (
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE		STreet or respiratory arrest,	Ballmore	Approximate Interval Between Onset and Death
,00	e executed ian and inial-transit	Examiner	Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
P.O. Box 68760,	hat the death certificate be executed of by the attending physician and letached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnancy  1	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day <b>Y</b> e ar
_	e d	Д.	Part II Other cignificant conditions	contributing to dooth but not reculting	in the underlying serves since in Deat I	22a Did tohan	an una contribute to th	he cause of death?

Be Completed by Medical Certification: To

To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be a

Division of Vital Records, P.O. Box 68760,

METASTATIC RENAL CELL CARCINOMA 2 No 1 ☐ Yes 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No ACUTE ON CHRONIC RENAL FAILURE 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigation Injury 1 ☐Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certi

29c. License number D37254

09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON POH LIM. 7601 TOWSON, MARYLAND 21204

State Registrar

OCT 26 2009



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 22, 8:00 A.M HELEN A. CHMIEL 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS BRIGHTWOOD CENTER BALTIMORE LUTHERVILLE 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** 112971921 Days 1 □ M 2 💢 F 214-14-1346 88 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a, State 1 ☐ Yes 2 ☐ Xio Director HOWARD COLUMBIA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or r must be r 21045 8657 WORN MOUNTAIN WAY USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. Specify: Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT SOCIAL SECURITY 8TH GRADE ortant: If item 27 is marked other injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H tem 27 is marked ott Be 2 JAN CHMIEL ANIELA DUL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS W. WRONKA/NEPHEW 8657 WORN MOUNTAIN WAY COLUMBIA, MD 21045 Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i any injury or 10/26/2009 HOLY ROSARY CEMETERY DUNDALK, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatu of Funeral Service Licensee MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZheimer ementia **Physician** day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9☐Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an cate has t certificate 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 Accident Injury 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Richard

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

5415

Bellona Lome #216, Towson MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32 Registrar's Signature

		1 - For State of Maryland / Registrar	Department of Health and N Certificate of Death	Mental Hygiene	34105
Phys	siciar	1. Decedent's Name (First, Middle, Last)		Date of Death     Month Day Year	3. Time of Death
	edica mine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	6ct 33 2009 4c. County of Dea	th
Fune	ral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Bir	thplace (State or Foreign
Direc		219-18-6332 <sup>1⊠ M 2□ F</sup> 86	Yrs. Months Days Hours Min.	(Month, Day, Year)	cyland
/land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	n or Location		10d. Inside City Limits
e Man 3a-fsh	100	MD Baltin	nore		1 ⊠Yes 2 ☐ No
with th	i	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
death ms 23	Cade	100 HarborView Drive Apt 1009  11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No	21230  13. Was Decedent of Hispanic Origin? (Sp	USA ecify Yes or No- 14. Race - Ame	erican Indian,
Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. This marked other than "natural", or Items 23a or 28a-f show requirents a point.		Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give Year or Dates: WWII	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		e, etc. Thite
5-0( 72 hou natura	130	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation     (Give kind of work done during most of work)	16b. Kind of Business	/Industry
121 within sine.	)da	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)  ecutive VP/Provost	University	.,
filed v	3	5+ Ex		(First, Middle, Maiden Surname)	у
ylan yuld be Menta arked	i i	Frank Cardegna	Mary Lou	ise D'Alassandro	
	1		o. Mailing Address (Street and Number or Run 00 HarborView Drive A		
Baltimore,  permit. Pages 1 an Department of Heal Important: if Item 2 any Inlury or other		cemete	erv. crematory or other place)	Date 20c. Location - City or 8/2009 Glen Burnie	
Baltimo permit. Page Department of Important: if	Çe.	21. Signature of Euperal Source Licensee	22. Name and Address of Facility Ste Funeral Home of Cat	rling Ashton Schwa	h Witzke
<b>10</b> 88 5 5	晑	MO1537	1630 Edmondson Aven	ue; Catonsville, M	ID 21228
Physicia		23a: Part : Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a		or respiratory arrest,	Approximate Interval Between Onset and Death
/Medic Examin	_	resulting in death)  Due to (or is a consequence			· · · · · · · · · · · · · · · · · · ·
	į	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):		VIII VIII
ecuted and -transit	Fyaminer	Cause (Disease or injury that initiated events resulting in death) Last			years
octificate be executed riding physician and se as the burial-transit	H Isola	Due to (or as a consequence	or):		•
C 68 ertificat ing phy e as the	Mod	IF FEMALE:			
death cer e attendir d for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	livery Day Year
that the ded by the detached	hveic	1   Yes 2   No 9   Unknown	5 Li Other (specify)		
ഗ ജ ക്ല	2		n the underlying cause given in Part I.	23e. Did tobacco use contribute to	
ecord law require as been si 2 should t	atalo			24a. Was an 24b. Were at	utopsy findings available
VITAL MEC sician: The law certificate has b	Completed by			autopsy prior to death?  1 □Yes 2 □ 10 1 □Yes	completion of cause of
OT VITAL Physician: T this certificat ral director, pa	8	examiner?	26. Place of Death	n <i>(Check only one)</i> me=5 ☐ Residence=6 <b>⊡∕</b> other <i>(Spe</i>	noify) 10.1 500
On Or ding Phy h. After this funeral d	Fion: T	27. Manner of Death 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b.		28d. Describe how injury occurred	ecify) ALF
DIVISION I or Attending after death. Director: Afte	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Co		e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause(s) and manner a ed at the time, date and place, and due	s stated. e to the cause(s)
To the vithin To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)
		Wend Klus mo	D 3/295	10/24/09	7
		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		
	State	31. Date filed (Whith Day Year)  32. Registrar's Signature	marana pue 1	Manue mo	21706
	istrar	ULINO BUUS PRICE P. 19	ares		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Josiah Cowley 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegan umberlan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Months Days Hours Min. March 2, 5. Social Security Number unk 9. Birthplace (State or Foreign Country) Texas 7. Age (In yrs. last birthday Months 1⊠M 2□ F 73 1936

10f. Zip Code

1 ☐ Yes 2 No

26719

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian,

Specify: White

USA

1 ☐ Yes 2 ☑ No

**Funeral** Director the Maryland 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 'amy injury or other traumatic event, the Wedlen Examinat must ben once. Baltimore, Maryland 21215-0036 **Physician** /Medical

1 - For State Registrar

10a. State

WV

Director

Funeral

Be Completed by

ဥ

Usual Residence of Decedent

10e. Street and Number

PO Box 802

11. Marital Status unk

1 ☐ Never Married 2 ☐ Married

3 Widowed 4 Divorced

10h. County

unk

12. Was Decedent Ever in U.S. Armed Forces? 1 愛Yes 2 □ No If Yes, Give Year or Dates: unk

10c. City, Town or Location

Fort Ashby

**Physician** 

/Medical

**Examiner** 

Examiner

Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Physician/Medical Be Completed by within 24 hours after death.

To the Funeral Director; After this certificate has I completely filled in by the funeral director, page 2 s Certification: To

Division of Vital Records, P.O. Box 68760,

15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usual ( (Give kind of work)	done during most of work	ing 16b.	Kind of Business/Industry
Elementary/Secondary (0-12) unk	College (1-4or 5+) unk	`life. DO NOT use deputy she	· ·		)klahoma
17. Father's Name (First, Middle, Last)		deputy sile		e (First, Middle, Maide	
19a. Informant's Name/Relationship (	Type. Print)	19b. Mailing Address (S	itreet and Number or Run	al Route Number, City	or Town, State, Zip Code)
Rick Wolford/frie				on; Spring	field, WV 26763
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specifi	Removal from State	ace of Disposition (Name emetery, crematory or othe	of C er place)	Date 20c.	Location - City or Town, State
21. Signature Funery Service Licen	Sade Director		Address of Facility hatomy Board re, Maryland		Baltimore Street
23a. Part 1. Enter the disease, or company shock, or heart failure. List only	ofications that caused the death.				Approximate Interval Between
Immediate Cause (Final disease or condition		CARCINOL	TA OFLU	146	Onset and Death
resulting in death)	Due to (or as a consequence				
Sequentially list conditions,	b	The Control			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):			
that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):			
	.d.				
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pred			23d. Date of delivery  Month Day Year
Part II. Other significant conditions of	ontributing to death but not resul	ting in the underlying caus	se given in Part I.	23e. Did tobacco	use contribute to the cause of death?
				1 ☐ Yes	2 No 3 Probably 4 Unknow
				24a. Was an	24b. Were autopsy findings available
				autopsy performed? 1 ☐ Yes 2 💢 N	
25. Was case referred to medical examiner?			26. Place of Death		
1 Yes 2 No	Hospital: 1 X Inpatient 2 ☐ E	R/Outpatient 3 □ DOA	Other: 4 D Nursing Ho	me 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	28b. Time of lnjury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, street, factory, of	fice	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one) Certifying Phr	ysician: To the best of my know iner: On the basis of examinati and manner stated.	rledge, death occurred at on and/or investigation, in	the time, date and place, my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	1.	29c. L	icense number	29d. D	eate signed (Month, Day, Year)
1) aboth	odle	D	00634	62	0113/2004
30. Name and address of person who of DR - Bl Anche M 31. Date filed (Month, Day, Year)	navromatis.	904 Set	on Drive,	Cumber	-land, mD 2150
OCT 26 2009	Cener B.	parkel			

Registrar DHMH 17 Rev 1/2001

Medical

State

OCT 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #IperME, 9896 10/26/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** CUMBERLAND, MARY 4.45 AM 2009 Mary Cumberland OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNSHOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F March 10,1927 Director 220-22-9270 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Examinating to a citifical event. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2x No Director Dunda1k Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 United States 810 Leswood Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. <u>۾</u> Specify: White 3√□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Provider Nurse's Aide 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Henry Bush Viola Kingdollar ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
810 Leswood Court Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) Sharon A. Terry (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/26/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Den't 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** -5 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): \* Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 2 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1√ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

10

State Registrar 31. Date filed (Month, Day, Year) 0CT 2 6 2009

MADHAVI

TINKA M.B.B.S y

ar)

8 2009

32 Registrar's Signature

8.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE BALTIMORE, MD 21224

RES-000

OCTOBER. 22 2009

		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death  Reg. No. 2009 341									
Physic	ian	Decedent's Name (First, Middle, La.					2. Date of De Month		Year	3. Time of Death	
/Medi	cal	4a. Facility Name (If not institution, giv	Alvi		ey, Jr	and another of D	10	22 20		1:40 ам	
Exami	ner	Joseph Richey	ŕ			4b. City, Town, or Location of Death Balto		N/A	4c. County of Death N/A		
Funeral		Social Security Number 6. S	ex 7. Ag	e (In yrs. last birth	(ay) If Under 1 Year	If Under 24 I		rth	9. Birthp	lace (State or Foreign	
Director		213-32-3343	<b>™</b> 2□ F	34 Y	s. Months Days	Hours N	Min. (Month, D 8-3-		Coun	MD	
and	7	sual Residence of Decedent  Da. State 10b. County 10c. City, Town or Location 10d						0d. Inside City Limits			
Maryl -f sho	to	MD	N/A	Baltin	ore					Y Yes 2 □ No	
h the r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	itry?	
23a c	ra [	804 N. Port Street			21205			USA			
er dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces? 1 ∐Yes 2 ☐	Ever in U.S.	<ol> <li>13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>			o- 14. Race Black	- Americ	an Indian, etc.	
rs afte	by F	1 🌠 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2* If Yes, Give Year or Dates:	No	1 □Yes 2 ☐No	Specify:		Specify:	Bla	ack	
5-00.30 72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Exanitar must be redified at	ted	15. Decedent's Ed	ucation	16a. C	ecedent's Usual Occu	upation		16b. Kind of Bus			
thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)						
led wi Hygier her th		llth grade	N/	'À	Disabled	т		Dis		ed	
ITE, INTALYISTICA ZIZIO-UUGO s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Modical Examination to provide at	Be	17. Father's Name (First, Middle, Last) Alvin Dudley,	Sr				Name (First, Middle ne Davi		;)		
should Me mark	2	19a. Informant's Name/Relationship (Type. Print)			Ialling Address (Stree			al Route Number, City or Town, State, Zip Code)			
alth a		Tara Dudley -S	ister	- 1	519 Old			lto, MD		, ·	
Pages 1 announce of the sant: If item		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐	Dames and from Charles	20b. Place of D	isposition (Name of crematory or other pla	ace)	Date	20c. Location - 0	City or To	wn, State	
rattimor rmit. Pages spartment of portant: If it y Injury or o		4 Donation 5 Other (Specify			mount		/24/09	Balto,	MD		
DCALLINGTE, permit. Pages 1 au Department of Hee Important: If item any Injury or othe once.		21. Signature of Funeral Service Licen	see /////	4	22. Name and Addr	,		East F/I			
		23 Part Enter the disease or complications that caused the mode of duling such as carried or complications are as a complication of the following the mode of duling such as carried or complications are as a complication of the following the following the mode of duling such as carried or complication are as a complication of the following the followi									
Dharisis	ı	23. Part 7. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each in .  Approximate Interval Between Onset and Death.									
Physician /Medical		Introducte Cause (Final lease or condition resulting in death)  Onset and Death  Onset and Death  Due to (or as a consequence of):									
Examiner											
pe #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of)	ince of):						
xecute and I-trans	Examiner	that initiated events resulting in death) Last	C	a consequence of)							
icate be executed physician and the burial-transit	dical E		Due to (or as	a consequence or,							
The law requires that the death certificate be executed are has been signed by the attending physician and agge 2 should be detached for use as the burial-transit			.d					- T			
leath certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	2 D Estania program	101/		23d. Date	of delive	ery	
e deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a					Month Day			
that the de ned by the stacked is	Phy	9 ☐ Unknown  Part II. Other significant conditions of		ut not reculting in th	a underlying equee of	ivan in Bart I	23a Did	tobacco uso co	uto to th	on pause of death?	
signe d be c	d by	HOARTITE	le underlying cause gi	venin ran i,		23e. Did tobacco use co ute to the cause of death?  1 ☐ Yes 2 ☑ o 3 ☐ Probably 4 ☐ Unknown					
w requires to seen significant should be or	letec	( ara bral odday									
The law te has age 2 s	Completed	- Cheller Pary						autopsy prior to completion of cause of death?			
	a	1   Yes   2   No   1   Yes   2   No   25. Was case referred to predical   26. Place of Death (Check only one)   21.								2 ∐ No	
Attending Physician: or death. ector: After this certific by the funeral director; I	D B	examiner?  1   Yes   2   Doo   Other: 4   Nursing Home 5   Residence 6   Other (Specify   Doo   Doo   Other)									
	ü	27. Man or of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?									
ttend death stor: /	icati	Accident investigation  3 Suicide 6 Could be	30a Place of Init	At home form		]Yes 2 □ No	006	(0)	-	10 at Namba	
after Direction by	Certification:	4 Homicide determined	building, etc	c. (Specify)	street, factory, office		City or To	(Street and Numbe wn, State)	r or Hura	I Houte Number,	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fun		29a. Certifier  (Chock cold)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
the Horin 24 the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
<b>~</b> ₽ ₹ ₽ ₺	2	29b. Signature and title of certifie	Vallago)	MD	29c. Licen	se number		29d. Date signed	(Month,	pay, Year)	
•		30. Name and address of person who	completed cause of d	eath (Item Ø3a) /Ti	ne Princ	10/2	1111	10/2	40	17	
		John Parme	4/100	1/hat	MAS S	4	27/10	My	21.	2/8	
Sta		31. Date filed Month, Day, (Jean)	32. Registra	ar's Signature	Co	- 1	01100	4	~		
Registr	ar	00100	<b>*</b>								

09-08087

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Franchest Dorsey State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Franchester Ollie Dorsey 2. Date of Death Physician/ Month Day October 18, 2009 0611 hrs Medical Examiner <del>Dorsey</del> <del>-Franchest</del> c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore** Sinai Hospital NA If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director  $_{2}X_{F}$ 09-07-53 216-62-2134 56 М Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1XX Yes 2 No 23a or 28a-f show MD NA Baltimore hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 4025 Hilton Road Funeral 14. Race - American Indian, Black. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Never Married Yes 2 Specify: American Yes 2 X No specify: Divorced If Yes, Give Yea 3 Widowed Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comple Cherrywood Baltimore, MD 21215-0036 12th Grade NANurse <u>Nursing Home</u> 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Edward Hatchett Ollie L. Dorsev 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Baltimore, MD 21215
Date | 20c. Location - City or Town, State Nathaniel Morris-Son <u>Hilton Road</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ng Mem. P 1 X Burial 2 Cremation 3 Removal from State King 10-24-09 Randallstown, MD permit. Pages
Department of
Important: I Pk. Cem. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva Physician Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X AMENDED #1 per ME g896 10/26/09 TT attending physician for use as the burial -UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year 2 Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 ✓ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ≥ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? performed? this certificate Yes 2 🗸 No Yes Nο 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital æ examiner? DOA Other: Inpatient Nursing Home 5 1 Yes No After t 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural 1 Yes 2 No To the Funeral Director; completely filled in by the f 5 Pending 24 hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. October 19, 2009 30. Name and address of person who completed cause of death (Item 23a 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner

State Registra

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Jr tarveu Drewer 03:00% October 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Mayland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 M M 2 □ F 220-32-9835 81 June 23 1928 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Virginia Accomack Saxis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20134 Saxis Road 23427 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2√2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Seafood Dealer Retail/Wholsale 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey V. Drewer Annie Furniss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andy Drewer (son) 20134 Saxis Road, Saxis, VA 23427 Date 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 John W. Taylor's Mem. Temperanceville, VA 21. Signature of Funeral 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia disease or condition resulting in death) Due to (or as a consequence of): transplantof allure renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 0 No

**Physician** /Medical Examiner

physician

attending

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After t

within 24 hours after death

To the Funeral Director:
completely filled in by the

Department of Health a Important: If item 27 Is any Injury or other trainonce.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

nd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be redified at

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-tran the as asn j signed by t page 2 should

requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician: The certificate

Hospital or Attending

death.

Examir Physician/Medical þ Completed Be မှ Certification:

autopsy 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 🗌 No

19006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

October 24, 2009

28d. Describe how injury occurred

1 ☐ Yes

(Check only one) 29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation

determined

6 ☐ Could not be

examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greenest. Baltimore, MD 21201 Jenny Tuan

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature DCT 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:45 2009 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** 1dwood -Kwai 8. Date of Birth birthday. 9 Birthplace (State or Foreign Funeral 1 □ M 2 👿 Director ral", or items 23a or 28a-f show Examiner must be notified at City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 □ No timore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Wildwood USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced ac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Seconday (9-12) College (1-4 or 5+) Be 18\_Mother's Name (First, Middle, Maiden Surnam ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 9nset and Death Immediate Cause (Final disease or condition Physician, 10 Medical resulting in death) Due to (or as a consequence of): Examiner GIV S reimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician; The law requires that the death certificate be executed page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation M within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State of Analytic Republic Periods Brown Br

2009	34	1		2
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		1- For State Ce Registrar	rtificate of	Death		Reg	No 200	19 3411
Physicia	_	Decedent's Name (First, Middle,Last)	Aiddle,Last)			2. Date of Death		3. Time of Death
Medical Examir	ner	Barbara A. Everett				Month October 8,	Day Year 2009	0557 hrs
		4a. Facility Name (if not institution, give street and number)	- 2	b. City, Town, c	r Location of Deat	1	4c. County of Deat	h
		Johns Hopkins Hospital		Baltimore				
Funeral		5. Social Security Numbeunk 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24Hr	8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or unit
Director		1_M 2XF	O Yrs.	Months Da		i.	Forei	ountry) Ohio
	ł	Usual Residence of Decedent	0 Yrs.			Oct 18,	_1968 I	OIIIO
any	H		, Town or Locati	on				10d. Inside City Limits
<u> </u>		MD Ba	7					1 Yes 2 No
Aaryland 28a-f show I at once	흱	10e. Street and Number	ltimore	10f. Zip Code		140	. Citizen of What Cou	
Mar r 28s	Director	2610 Mura Street		· ·	21212	100		muyr
ith the Maryland 23a or 28a-f she notified at once				l	21213		USA	
t be	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?	1434		ispanic Origin? ( S an, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
r dea or it	ᆵ	Yes 2 👗 No	unk			•		
s afte	至	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X N				nite
hour natu Exan	B	15. Decedent's Education (Specify only highest grade completed)	16a. Deceden during me	t's Usual Occupa ost of working lif	ation (Give kind of e. DO NOT use re	ired)	16b. Kind of Business	Industry unk
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)						
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215-0036 be filed within 7 ntal Hygiene. *ked other than ent, the Medica	Ol	17. Father's Name (First, Middle, Last)		unk	18.Mother's Nam	e (First, Middle, Ma	aiden Surname)	unk
21215-00 und be filed wit Mental Hygien marked other c event, the M	o Be	19a. Informant's Name/Relationship (Type, Print )	405 Mailia	Addres (0)				
	ř	O.C.M.E. Austria/ friend	1 1 614	Longwood	od Court.	. Edgewo	er, City or Town, State od MP 2104 21201	e, Zip Code) 10
MD and 2 sho salth and 2 sho salth and raumatis	H		Place of Dispos			Date M	D 21201 20c. Location - City o	
SE 1 a of He		1 Burial 2 Cremation 3 Removal from State	crematory or oth		emetery,	Date	200. Location - City o	Town, State
Pages Pages ment of tant: If		4 Donation 5 X Other Specify: in state						
Baltimore, permit. Pages 1 an Department of Her Important: If ite		21. Signaturo Funor Service Licensee Ronald 8. Walk Wirecto	22. N	lame and Addres	ss of Facility	d 655 W	Baltimore	Street
<b>m</b> 89 = :								Street
Physician	1	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	n. Do not enter th	ne mode of dying	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate on se (Final disease a. Sepsis						Death
Adminer	- 1	or condition resulting in death)  Due to (or as a consequence	of):					
	_	Sequentially list conditions, b. Bacteremia						
	miner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	of):					
	~ ~ ·	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence	of):					
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8760, ifficate be exage physician us the burial	g r	IF FEMALE: 23c. If yes, outcome of pre		/, per	ME 889/	1/9/09 1	23d. Date of delive	rv
187 rtifica ing p	> I:	23b. Was decedent pregnant in the past 12 months?		tal death 3	Ectopic pregn	ancy		Day Year
Box 687  Re death certific  The attending pred for use as the	Physiciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)						
Box ne death c the atten	F)	1 Yes 2 No 9 V Unknown g Unknown						
P.O. s that th gned by e detach		Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause	given in Part I.		acco use contribute to	
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of Vital Records, ng Physician: The law requir ther this certificate has been s metal director, page 2 should	Completed					24a. Was ar		utopsy findings available completion of cause of
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Vital Reco ysician: The law his certificate has director, page 2 s		25. Was case referred to medical		00 Di-	(D	1 Yes 2	V No 1 Y	es 2 No
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Division tal or Attendi rs after death al Director: A	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At I	nome, farm, stree	et, factory, office	building, etc.	28f. Location (St or Town, Sta		ural Route Number, City
Spital nours neral	OF	4 Homicide determined (Specify)				ļ		
		29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) Region Medical Examiner: On the basis of examination.	-					
To th Within	Medical	and manner stated.	and/or investigat			at the time, date a		
	Σ	29b. Signature and title of certifier			ise number		29d. Date signed (Mo	,
		Hamek & outhall MA		0.0	.M.E.		October 9, 2009	)
		30. Name and address of person who completed cause of death (Itel	,	-				
		Pamela E. Southall, MD Assistant Medical Exa		1 Penn Stre	et, Baltimore,	MD 21201		
Sta	ate	31. Date filed (Month, Day, Year) 2009 32 Registrar's Signal	1. par	del .				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6.50pm 2009 redrick 0 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner reducil Del AIR 1050 Upper Chesaperine 9. Birthplace (State or Foreign Country) NorthCarolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 29, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** <sup>Year)</sup> 1946 Min 1**3234**M 2 □ F Months Days Hours 527-68-0517 Yrs Director 63 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show 1 ☐ Yes 2x No Funeral Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 Virginia Avenue 21014 United States 12. Was Decedent Ever in U.S. Armed Forces? ↑ The Ses 2 No 1965— If Yes, Give Year or Dates: 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after (ealth and Mental Hygiene. n 27 is marked other than "natural", or iter 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Artillery Tester Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Warren Fullwood Mildred Thompson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Fullwood / Wife 3 Virginia Ave. Bel Air, Maryland 20b. Place of Disposition (Name of Evans Funeral Chapel 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State oct. 23,2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Air 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—Bel Air 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) on within How f Failur **Physician** /Medical Due to (or as a consequence of): Examiner 1 Jercosu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to The law requires that the death certificate be executed Box 68760 € Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 PNo 1 ☐ Yes 2 🗔 📈 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by determined 4 Homicide To the Hospital 29a. Certifier 🟲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 1669600326 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier ddress of person who completed cause of death (Item 23a) (Type, Print) 500 yperchesapeske Dr. Belkir MO 21019 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.0.

Division of Vital Records,

Eugene Gash 09-07998 UNK UNK Registrar Physician/ Medical Examiner 5. Social Security Number **Funeral** Director 10a, State unk Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number Funeral 11. Marital Status Never Married Widowed ģ Completed Be 20a. Method of Disposition Physician Medical aminer Sequentially list conditions, if any, leading to immediate Examiner and transit Physician/Medical X UNPENDED attending physician or use as the burial past 12 months? has 2 sl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 34114 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle,Last) Month Day October 14, 2009 2015 hrs Eugene Gash 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltimore 611 E. Biddle Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 6. Sex 7. Age (In yrs, last birthday) Days Months Hours Min Country) Ohio 239-72-0276 1 X M 2 F 09/02/1948 Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10b. County unknown unknown 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code unknown unknown U.S.A. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Yes Yes, Give Year Yes 2 X No specify: Specify: Black 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 2 Chef Restaurant 18.Mother's Name (First, Middle, Maiden Sumame) unknown 17. Father's Name (First, Middle, Last) Andrew Gash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) Kwandra Gash/Daughter 3798 Austin Park Lane, Decatur, GA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State 10/23/2009 Hanover, Maryland Ardent cremation Services Donation 5 Other Specify: 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee Zama C. Hardeste 7522 Connelley Drive, Ste.N, Hanover, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line. Death Heroin intoxication Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Records, P.O. Box 68760,
The law requires that the death certificate be executed AMENDED 23a,27,28a-f,perME, g896 10/28/09 TT 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No : certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: **Division of Vital** Be Other: Hospital: 1 Nursing Home 5 Residence 6 ✓ Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Yes 2X No unk Director: Pendina within 24 hours after death. 10/14/09 Fd 8:05 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 611 E. Biddle St Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide (Specify) Found: in vacant building To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 15, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day Year) OCT 26 2009 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

ORIGINAL

OCME

# VOID

# CERTIFICATE #

2009 - 34115

SEE

CERTIFICATE #

2009-35024

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Edward Jerome Griggs 2. Date of Death Month Day 2009<sup>ear</sup> Oct. 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Levindale Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 ☐ F 214-38-2494 68 1941Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland N/A Baltimore M∑Yes 2 No 10e. Street and Number 10f. Zip Code 21 21 5 10g. Citizen of What Country? 3335 Avondale Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ **X**ever Married 2 ☐ Married Spec Black 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO\_NOT use retired) Baltimore County Elementary/Secondary (0-12) 10th grade College (1-4or 5+) Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Gaines Elijah Perry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie Mae Reynolds/ Companion 3335 Avondale Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Alphonsus Cemetery 10/29/09 **½** Burial 2 ☐ Cremation 3 □Removal from State Woodstock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Like 22. Name and Address of Facility Chatman-Harris FuneralHome arro 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part1 Enter the disease shock, or heart failure. I e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOXIC ENCEPHALOPATH disease or condition resulting in death) Due to (or as a consequence of):

**Physician** /Medical Examiner Examiner certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified

Baltimore, Maryland 21215-0036

the Maryland

attending physician and for use as the burial-transit Physician/Medical the þ been signed b should be deta Completed by page 2 certificate Be Certification: To After t ithin 24 hours after death.

b the Funeral Director: A

mpletely filled in by the fu

Division or Vital Records, P.O.

the Hospital or Attending Physician:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPOGLYCEM!  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.	(4		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	me 5□ Residence	6 ∏Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) LC Certifying Pl	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place, gation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
20h Signature and title of certifier		29c License number	00-1-5	Sets siered (Mary 19 Dec Weed)

D0063327

2000

AVE, BALTIMORE, MD

State Registrar

Medical

OCT 26 2009

31. Date filed (Month, Day, Year)

2434 W. BEWEDERE GIZAW WELDEHIWOT,

WOLDEHOWO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amend #26, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Loritta Laverne Hege OCT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min 198-34-6499 65 Director June 1944 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Modical Evan in marines notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits unk Director 1 ☐ Yes 2√ No PA Chambersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17201 USA PO Box 1402 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No 2 Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Earl Youngblood Ethel Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 1402; Chambersburg, PA 17201 Joseph Hege/husband permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signa ire i Funeral S rvice Licensee Ronald S. Wader 22. Name and Address of Facility Viteotor State Anatomy Board; 655 W. Baltimore Street 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** coron /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe Division of Vital 2 No 1 ☐Yes 2 ☐No 1 □ Ye*s* • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 17 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DU011266 thein Ave Hagerstown, MD 21742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Weeks 5,80 Northern toward

DHMH 17 Rev 1/2001

State

Registrar

legistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 4:50 P M William Bertram Hollman, Sr. October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie 439 Rogers Avenue Anne Arundel 9. Birthplace (State or Foreign Country) Maryland Date of Birth (Month, Day, Year) 9/24/1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Min. Months Days 1**∑**M 2□ F 81 214-26-0319 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "motical Eventine must be notified at once. 10a. State 1 □Yes 2 No Anne Arundel Glen Burnie Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 439 Rogers Avenue 21061 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No SpecifyWhite Ş Q 3 N Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Henry Lewis Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Contractor 18. Mother's Name (First, Middle, Maiden Surname, Geneva Pilcher 7. Father's Name *(First, Middl*e, *Last)* Alfred Hollman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2218 Harvest Farm Road, Eldersburg, Maryland, 21784 Michael HOllman, Sr. / Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 10/26/2009 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, 7250 Washington Blvd., Elkridge, Maryland, 21075 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final V Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 □No certificate ospital or Attending Physician: The hours after death.

Lineral Director: After this certificate by filled in by the funeral director, pag 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

GlenBurnie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) レみレズノブ

32. Registrar's Signature

610 Crain Towers

31. Date filed (Month, Day, Year)

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			For	State of Marylar	•				01.1.1.0
			1 - State Registrar		Certifica	te of Death	Reg.	No. 2009	34119
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	Funeral		Social Security Number 6.	Sex 7. Age (In yrs		er 1 Year   If Under 24 Hrs Days Hours Min.		9. Birthpl	ace (State or Foreign
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	р.		Usual Residence of Decedent						
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P.1	Ba-f s	Director	mo Har	tord F	orest	HIII			
72	or 2	Dire	10e. Street and Number	0	10f. Z	ip Code	10g.	Citizen of What Count	try?
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0)	r deg	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? ( ecify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	an Indian, tc.
36	or i	by F	1 ☐ Never Married 2 ☐ Married	1 ⊟Yes 2 No If Yes, Give	1 □Yes	2 No Specify:		Specify: Wh	ite
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OCTOBER 21, 2009 Baltimore, Maryland 21215-0036	Pages nent of i		1 ☐ Burial 2 🗹 Cremation 3 📗	Removal from State	cemetery, crematory or	other place)	23-09 F	Forest H	am, Illi
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ĕ	atter for u	cjar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of				1	Day Year
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	n requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
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HOUCHINS, Division of	after after Dire	Certification:	4 Homicide determine	building, etc. (Spec	cify)	,	City or Town, S	tate)	
F	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	a C		hysician: To the best of my kr					
	e Ho 1 24 h e Fu letely	edical	(Check only 2 Medical Exa	miner: On the basis of examir and manner stated.	nation and/or investigati	on, in my opinion, death occ	curred at the time, date	and place, and due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/ / /	2	9c. Licens number	29d.	Date signed (Month,	Day, Year)
			1 / Carl	e de		4/15		10-21-09	
	11		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Print)				
	H		EDDIE NAKHUDA		DULANEY VAI	LLEY ROAD T	IMONIUM M	D 21093	
	Sta	ite	31. Date filed (Month, Day, 2009	32. Registrar's Sign					
	Registr	rar	PART & D CARS	Census A.	10 60 0 CO				

State of Maryland / Department of Health and Mental Hygiene 34120 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 10:38 P M Ronald Ellsworth Harper October /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3 Bristol Hill Court T2 Baltimore Catonsville 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 23, 5. Social Security Number **Funeral** 1925 Months Days Hours Min. 1 X M Director 219-10-2196 83 Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Experience must be retified at Director 1 □Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Bristol Hill Court T2 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican. etc.) 11. Marital Status 14 Race - American Indian 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ∐Yes 2 🛣 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien, Important: If Item 27 is marked other the any injury or other traumatic event, the once. 12 Management Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Harper Lillian Shaffer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bristol Hill Court T2; Catonsville,MD 21228 Wife Bernice Harper 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park 10/24/2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsvile, MD 21228 21. Signature of Funeral Service Licensee 10000 23a. Part 1. Enter the diselve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 409 m /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the a∏Unknown 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 DNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 1 □Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home State Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 □Yes 2 □ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) Medi 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 0 ( 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 26

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DIANE LANE HECKNER 2009 8:03 October 0 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 220-42-6227 Director 64 24,1945 April Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8029 Rider Avenue 21204 Completed by Funeral USA HECKNER DION Baltimore, Maryland 21215-0036 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2XX Married 2 **X** X 0 1 □ Yes 2**X**No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, The Man Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Clerk 17. Father's Name (First, Middle, Last)
Melvin Lane 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F Heckner Hus 8029 Rider Avenue Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1) Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Oct 29, 2009 Owings Mills, Maryland Donation 5 Other (Specify) 22. Name and Address of FaMivtchell-Wiedefeld Funeral Home Inc nature of Funeral Service mus 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mehspir breast cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Hospital or Attending Physician: The law requires that the death 3 🗆 Ectopic pregnancy 0 Day Year 5 Other (specify) signed by the a P.0. 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s certificate performe 2 No 1 ☐ Yes 1 □ Yes r this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death

Director: A in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af e Funeral Di etely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar

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29b. Signature and title of certifier

Shupa 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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D.C

29c. License number

889800H

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Sta Hmore 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21229 or items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Newer Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. "natural", Completed 3 ₩Widowed 4 ☐ Divorced ac 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Ipformant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositie 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount I to. Signature of Funeral Service Licensee MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition one dar Medical resulting in death) Due to (or as a consequence of): <sup>(</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a gensequence of the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death detached g Unknown 9 Unknown is been signed by the 2 should be detach∈ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed 1 Yes 2 No 2 € 1 🗌 Yes 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No Be ( the funeral director, 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D0058860 DCT 23, 2009

State Registrar 30. Name and address of per

31. Date filed (Month, Day,

Paltimore

who completed cause of death (Item 23a) (Type, Print)

**Physician** /Medical **Examiner** law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Box 68760, Division of Vital Records, P.O.

Examiner

Physician/Medical

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Completed

Certification: To

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Even her must be nothed at

Department of Health an Important: If item 27 is any injury or other trau once.

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

3 Suicide

4 Homicide

1 ☐Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier,

D 23300 october 20 ND 12 13 11 AZ BUN SECONRS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. PATEL SUDHIR 2600 W. 13A-270 5T. 21223

State Registrar

31. Date filed (Month, Day, Year) OCT 26 2009

6 Could not be determined

32 Registrar's Signature

Hospital or Attending Physician: The

certificate |

After this

To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu

funeral director,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 896 10/26/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 7:50 PM 20 2009 /Medical 4a. Facility Name (If not institution give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hosp Bultimore Ta bor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1□M 2∰F Months Days Hours Min. Country) Maryland 07-01-1920 220-12-8938 89 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1690 Kirkwood Road 21207 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2xxNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Barth Alice Warfield 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice M. Worsham - daughter 622 Ross Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 10-24-2009 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic **Physician** disease or condition resulting in death) days /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Yes 2 No 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No al or Attend s after death. 2 Accident filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide determined 4 ☐ Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) mo 21225 32. Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Mary State		artment of F ertificate of			iene •g. No 2 () () 9	34126
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
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Andrew San	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
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Н	Funeral Director		5. Social Security Number 6. Sex 7. Age (1 219-30-1527 1 M 2 F 76	In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign country)
	ъ		Usual Residence of Decedent		1		Aug 2	1933	MD
	ırylan show		10a. State 10b. County 10 MD Howard	Oc. City, Town or Lo					10d. Inside City Limits
	Ba-f	Director		Colum					1, ☐ Yes 2 ☐XNo
	a or 2		10e. Street and Number		10f. Zip Code		10	Og. Citizen of What C	ountry?
	ns 23	Funeral	7623 C Weatherworn Way  11. Marital Status  12. Was Decedent Eve	r in U.S 13	Was Decedent of H		ecify Ves or No.	USA 14. Race - Am	erican Indian
9	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Evan' har must be multiful at		Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
003	ours a	d by	3 ☐ Widowed 4 【 Divorced If Yes, Give TA Year or Dates:		1 □Yes 2 No	Specify:		Specify: wh	ite
15-(	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	ı (Give	edent's Usual Occup kind of work done	durina most of work	ing	6b. Kind of Business	s/Industry
12	withir iene. <b>than</b>	duc	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired	ッ derwriter		insurance	
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/lar	uld be Menta Irked Itic ev	To B	Joseph Lendle			Gertrude	Pauline	Werner	
lar)	2 sho and l		19a. Informant's Name/Relationship (Type. Print)					City or Town, State,	
ره ک	and Health Im 27 Iher tr		Kimberly Sheldon (daughter)					le, MD 21	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan The Trau De putflied at once.		1 Burial 2 X Cremation 3 Removal from State		matory`or other plac	ce)		20c. Location - City or	
Ħ	it. Partme		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee			ion 10-22		ykesville	
Ba	Dep Impo		Day Jaight Sterbert	P	.O. Box 1	<sup>ss ог гасыну</sup> наі 95 Sykesv	gnt Fune ille, MD	ral Home 8	& Chapel
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	HUPON	110				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a co	nseq ence of):	^				
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	cuted id ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	e exerian ar	Ex	resulting in death) Last Due to (or as a co	insequence of):		·- ·-			
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d						
		/Mec	IF FEMALE:						
Вох	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year
Records, P.O.	t the c	hysi	1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown 9 ☐ Unknown						
S,	uires that the de signed by the a	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ğ	w require s been sign should b	ed k					1 ☐ Ye	s 2.∰Mo 3⊟P	robably 4 🗀 Unknown
ec	e law r has be	plei					24a. Was an autopsy		utopsy findings available completion of cause of
E	: The cate h	Completed					perform	ed? death? DNo 1 □ Yes	•
Vita	sician: The certificate h rector, page	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death			
ō	Physer this eral dir	5	1 ☐ Yes 2 1 No Prospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		4 Li Nursing Hol	me 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
0	nding Ph tth. :: After th e funeral	atior	1 Natural 5 ☐ Pending (Month, Day, Ye 2 ☐ Accident investigation	ear) Injury	f 28c. Injur Work	ໃ?ື່ Yes 2 ∐No	Lod. Describe nov	winjury occurred	
Division of	r Atte er dez rectol by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (5	At home, farm, str	eet, factory, office		28f. Location (Stre	eet and Number or R	ural Route Number,
٥	ital ol rrs aft ral Di lled in	Cer	201811.91			- 8	City or Town,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, the funeral director is a function of the funeral director.	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.	amination and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)
	Vithir comp	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Moni	
			Jasmon und		022	247	)	0-22-2	2009
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)				
			JOSON OA  31 Date filed (Month Day Year) - 32 Benietrarie	22 S	Green	e st Bo	Ltimos	0-22-2	21021
	Stal Registra	e ir	31. Date filed (Month, Day, Year) 32. Registrar's OCT 2 6 2009	The state of the s					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 20, 200'9 LIVINGSTON 7:55 P M RAISA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A BALTIMORE CITY 3031 FALLSTAFF ROAD, #107 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F Months Days Hours Min. 05/04/1927 MD 215-22-0759 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1X Yes 2 □ No N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? USA 3031 FALLSTAFF ROAD, #107 21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces? ☐Yes 2 X No 1 Never Married 2 Married 1 □Yes 2 No WHITE If Yes, Give Year or Dates: Specify: Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSEMAN EVA KAMEROW SAMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 BY WOODS LANE, STEVENSON ,MD 21153 HOWARD SCHLOSS/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) OHEB SHALOM MEM. PARK 10/23/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

**Physician** /Medical Examiner

burial-transi

attending physician for use as the buria

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signed by t d be detach

page 2 should

has

certificate

After this

within 24 hours after death To the Funeral Director: completely filled in by the Physician/Medical

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Completed

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Certification: To

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law requires that the death certificate be execu

Hospital or Attending Physician: The

To the

Division of Vital Records, P.O. Box 68760

**Physician** 

**Examiner** 

Director

Funeral

2

Completed

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MD

**Funeral** 

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Examinar must be notified at

Baltimore, Maryland 21215-0036

/Medical

Examiner

shock, or heart failure. List of shock, or heart failure. List of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a consequence of):  Due to (or as a consequence of):	Tao In  Tao In  Tao In
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year

9 Unknown

23e. Did tobac	co use con	tribute to the cau	se of death?
1 ☐ Yes	20 No	3 ☐ Probably	4 Unknow

	1 Yes	No 3 Pro	idadiy 4 Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 □ No		opsy findings available ompletion of cause of 2 No
26. Place of Death (	Check only one)	•	

(Specify)

25. Was case referred to medical
examiner? ^
1 ☐ Yes 2 ☐ No
1 163 Z 100
27. Mainer of Death
27. Marrier of earth

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

: 4 ☐ Nursing H	ome 2	5 Residen	ce 6	Other
at	28d.	Describe how	injury	occurre

Natural	5 Pending
2 Accident	investigatio
3 Suicide	6 ☐ Could not b
4 Homicide	determined

28c. Injury Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier
(Check only
one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			n (Street Town, Sta		ber or F	Hural Hou	ite Number
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29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stat

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7	ame and	dress o	f person wh	o orașioni	ed cause	of deali	(Item 🗸 a	) (Type,	Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ам Svlvia Mozella 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Blue Point N/H Baltimore Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) N.C. Days 1 □ M 2**X X** Months Hours Min 2-24-1934 Director 250-64-7840 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 🗶 Yes 2 🗌 No MD N/A 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 S Α 3702 Grayson Street items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc "natural", or Completed by 1 Never Married 2 Married 1 G Yes 72 hours after Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: 3XXWidowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) unk Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Nelson Roosevelt Vereen should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 N.Fulton AVENUE Balto, MD 21217 Shirley Davenport-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 ; 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-30-2009 Owings Mills, Garrison Forest permit. East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ADVANC DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death the 9 Unknown g 🗌 Unknown P.O. ned by signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ ا Records, cate has been siç ; page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 NO Yes After this certification of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Hursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After appleted filled in by the funeral (Month, Day, Natural 5 Pending work' Division 2 🗌 No 1 🗌 Yes ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Contifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2-To the F complet only one) Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date sinned (Month, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Sig

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Physician   Mary E. McCray   Mary E. M					-				•	Are Legible.		
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The part is the part of the part is the past 12 months?  1	/Me Exar	edical miner	caminer	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Linet Underlying Cause (Disease or injury that initiated events	Due to (or as a co	insequence of):	-		r respiratory a	irrest,	Interval Between Onset and Dear	ath o
23e. Did tobacco use contribute to the cause of the cause of the contribute to the cause of the cause of the contribute to the cause of the	O. Box 68760, the death certificate be e	attending physicis or use as the bur		23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	regnancy		су				ır
24a. Was an autopsy performed? 1   Yes   Yes   No   24b. Were autopsy findings prior to completion of or death? 1   Yes   Yes   No   25c. Was case referred to medical examiner? 1   Yes   Yes   No   25c. Was case referred to medical examiner? 1   Yes   Yes   Yes   No   25c. Was case referred to medical examiner? 1   Yes   Yes   No   25c. Was case referred to medical examiner? 26c. Place of Death (Check only one) 27c. Manner of Death 27c. Manner of	rds, F	igne be c	þ	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.				
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 M Residence 6 Other (Specify)  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined determined determined.  28b. Time of Injury Work? M 1 Yes 2 No  28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury occurred.	Tital Reco	ate has						26. Place of Death	autor perfo 1 □ Yes	prior to death?	completion of caus	ilable e of
28d. Describe how injury occurred	of \	this o		1 ☐ Yes 2 🗖 No	1   Inpatient		IL 3 LI DOA	4 🗆 Nursing Hor			ecify)	
So to	on o	After	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time of Injury	Wor		28d. Describe I	how injury occurred		
City or Town, State)	Division all or Attents after deat	al Director: ad in by the	Sertifica	2 1 100100111	28e. Place of Injury - building, etc. (S	 At home, farm, stro pecify)			28f. Location (: City or To	Street and Number or R wn, State)	ural Route Number,	;
29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number.  29d. Date signed (Month, Day, Year)	he Hospit	ne Funera pletely fille		(Check only 2 Medical Examine	er: On the basis of exa	y knowledge, death amination and/or in	n occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	To t with	com	2	29b. Signature and title of certifier	ope ugo	)	29c. Licens	se number		29d. Date signed (Mont	th, Day, Year)	)9
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				30. Name and address of person who com	pleted cause of death	(Item 23a) (Type,	Print)	Lovk V	2 20 1	1 . H 2 - 1	e Min	1100
State Registrar  OCT 2 6 2009  32. Registrar's Signature		Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	41)	JOIN T	way	-unervi!	0 111112	109
DHMH 17 Rev 1/2001				001 26 2009	Course p	1. park						

			Please Type or Print in Black Indelible Ink. Ensure Al amend items 7.8 per fb g896 10-27-09 vt State of Maryland / Department of Health and N 1- State amend item 5 per inf g902 4-20-10 vt Certificate of Death	II Copies Are L Mental Hygiene	egible.
					2009 34180
	Physici /Medio		1. Decedent's Name (First, Middle, Latt)  MigNoN Mooke	2. Date of Death Month Day	-09 ar 3 m
1	Examir	ner	4a. Facility Name (If you institution, give street and nymber) 4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4c. Sacial Security Number  4c. Sex  17. Age (In vis. last birthday)  15. Sacial Security Number  4b. City, Town, or Location of Death	7	SALLIMOLE  By Birthplace (State or Foreign
	Funeral Director		5. Secial Security Number 5. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month) (Month) (197)	9. Birthplace (State or Foreign County)
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 □Yes 2 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 10f. Zip Code 21208	10g. Citize	en of What Country?
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evertinal must be notified at	₽ 	11. Marital Status  1 Never Married  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 No Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: DIACK
21215-0036	ad within 72 h ygiene. <b>er than "natu</b> t, the Mudical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Segndary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)  Elementary/Segndary (0-12)  College (1-4or 5+)	ing 16b km	of sings/Industry
Maryland	should be filled withind Mental Hygiene.  marked other than umatic event, the	To Be	17. Father's Name (First, Middle, Last)  18. Magner's Name  18. Magner's Name  34/1/12	e (First, Middle, Mailten Si E WilliA)	urname) MS
	is 1 and 2 sho of Health and item 27 is ma other trauma		194 Majiling Address Street and Number or Run  20a. Method of Disposition  20b. 61: 30 Disposition	ANE DA	TOWN, State 21 Cody 1208
Baltimore,	Page nent c		Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify)	79-01 BA	to. COUNTY
Bal	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensel 22. Name and Address of Facility 304 N, CENTRAL	AVE BAK	10. W.J. 21282
No.	Physician /Medical Examiner		23a. Fart F. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause in such line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	To W	Approximate Interval Between Onset and Death
	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
68760,	D .E .E		resulting in death) Last  Due to (or as a consequence of):  d		
O. Box 6	law requires that the death certificate be as been signed by the attending physici: 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	23	dd. Date of delivery Month Day Year
rds, P.	w requires that the d s been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
Il Records,	The law rec cate has bee page 2 shou	Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐Yes 2 ☐No
Vita	siclan: certific irector,	Be	examiner? Other:	h (Check only one)	
n of	ng Phy (fter this ineral d	on: To	Timpaterit 2 Envolupatient 3 DOA 4 Nursing Ho	ome 5 Residence 6 ( 28d. Describe how injury of	
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	2 Accident investigation M 1 Yes 2 No	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
,	Hospit 24 hours Funera stely fille	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) a red at the time, date and p	and manner as stated. place, and due to the cause(s)
)	To the within To the comple	Mec	29b. Signature and title of certifier  29c. License number	29d. Date	signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5 Are B	1819, MD 21215
	Sta Registr	re	31. Date filed (Month, Day, Year)  32. Registrar's Signature		1 -11 11 01013

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and N		ene I. No. 2009 34   31
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Charles Robert Mock		2. Date of Death	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) 3516 Moylan Drive	4b. City, Town, or Location of Death	October	19, 2009   8:30 A. M  4c. County of Death  Prince George's
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 02–22–19	9 Birthplace (State or Foreign
	e Maryland r <b>28a-f show</b> notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☒ Yes 2 ☐ No
	with the 23a or st be	eral [	10e. Street and Number 3516 Moylan Drive	10f. Zip Code 20715		g. Citizen of What Country? U.S.A.
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I file and Zi is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ▼ Yes 2 □ No  If Yes, Give  Year or Dates.1962-1984	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	vithin 72 ho liene. Ir than "nat the Medica	Completed by	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of work OO NOT use retired) ician	ing	Sb. Kind of Business Industry Health Care
yland 2	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Ernest Leighton Mock	18. Mother's Nam	e (First, Middle, Mai ¶ae Davis	den Surname)
, Mar	ind 2 shoul lealth and im 27 is m her traum		Bette Marie Mock/Wife 3516	ng Address (Street and Number or Rura Moylan Drive, Bow	vie, Mary	land 20715
Baltimore,	. Page 1 a tment of H tant: If ite jury or otl		4 Donation 5 Other (Specify) Maryland	matory or other place) Veterans 10/26	6/2009 C	c. Location - City or Town, State
Bal	permit Depar Impor any in		Jelin 1	6000 Annapolis Roa	ad, Bowie	
	hysician Medical Examiner	100	23a Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Bladder Cancer  Due to (or as a consequence of):	er the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death years
		dical Examiner	Sequentially list conditions, if any leading to knowclett cause. Enter Underlying Cause (Disease or linjury that initiated events			
09	ate be exec ohysician ar the burial-ti	dical Ex	resulting in death) Last  Due to (or as a consequence of):  d.			
. Box 687	Attending Physician: The law requires that the death certificate be executed at death.  **Teath.** ector. Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	v requires that the second second by should be deta		Part II. Other significant conditions contributing to death but not resulting in the Thrombocytopenia	underlying cause given in Part I.		cco use contribute to the cause of death?
Division of Vital Records,	sician: The law rec certificate has bee irector, page 2 sho	Completed by			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  ☐ No 1 ☐ Yes 2 ☒ No
/ital	rsician: s certifi director,	To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Check		te 6 Other (Specify)
on of \	anding Physician: 1 aath. or; After this certifica ne funeral director, p	Certificate: T	27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation  28a. Date of injury (Month, Day, Year) injury		28d. Describe how	
Divisi	ital or Atte urs after de ral Directo led in by tl		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st. building, etc. (Specify)		City or Town, S	
5X1	To the flospital or Attendi within 24 hours after death. To the Funeral Director. A completed filled in by the ft	Medical	29a. Certifier  (Check Check only one)  1	stigation, in my opinion, death occurred at death occurred at the time, date and place	t the time, date and pose, and due to the ca	blace, and due to the cause(s) and manner stated. use(s) and manner as stated.
•	<b>7</b> × <b>7</b> 00			29c. License number D54853		I. Date signed (Month, Day, Year) 0 / 19 / 2009
			30. Name and address of parsar who completed cause of death (Item 23a) (Type, Danny E. Lee, MD., 1132 Annapolis Ro	· ·	1113	
į	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ked		

DHMH 17 Rev 7/2009

Roslyn McClean 09-07874 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nk Unk		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar  State of Maryland / Department of Health and Mental Hygiene amend #1 Per ME C897 11/03/09 Registrar  Reg. No. 2009 341
Physicia ledical Examir		1. Decedent's Name (First, Middle,Last)  Roslyn McClain  4a. Facility Name (if not institution, give street and number)  2. Date of Death Month Day Year October 10, 2009  4b. City, Town, or Location of Death 1646 hrs
Funeral Director		3428 Hilldale Place  5. Social Security Number und 6. Sex 219-62-5931  1 M 2 K 54 Yrs.  Baltimore  Feb 28, 1955  1 S. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of under the protein Washington Country) DC
S Maryland 28a-f show any 1 at once,	or	Usual Residence of Decedent
th the Maryland 3a or 28a-f sho	I Director	10e. Street and Number 3002 Thorndale Avenue 10f. Zip Code USA 10g. Citizen of What Country? USA
after death wi	by Funeral	11. Marital Status  1  Never Married  1  Never Married  3  Widowed  4  Divorced  1  Yes  2  No specify:
5-0036 iled within 72 hours Hygiene. I other than "natur:	leted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Unik  College (1-4 or 5+)  Domestic  16a. Decedent's Usual Occupation (Give kind of work done unik do
ID 21215-003 should be filed withing and Mental Hygiene. 7 is marked other in artic event, the Med	To Be Co	17. Father's Name (First, Middle, Last)  Russell McClain  18. Mother's Name (First, Middle, Maiden Surname)  Anthura Jenkins  19a Informant's Name/Relationship (Type, Print) Tonia Jenkins/ Daughter  19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350/ W. Mulberry St. Baltimore, MD 21229
s I and of Health		O.C.M.E.  111 Penn Street Baltimore, MD 21201  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr		4 Donation & Worner Specify in state Mt. Zion Cemetery 11/3/2009 Lansdowne, MD  21. Signific of Funeral Service Licenser Director  Baltimore, MD 21201 21217
Physician /Medical xaminer	ner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):
executed in and il - transit	cal Examine	Cause. Enter Underlying Cause (Usease or Injury triat initialed events resulting in death) Last  Due to (or as a consequence of):  d.  X UNPENDED  X AMENDED  10/27/09 TT/5,16a-b,20a-c, 22, per Fh g896 10/29/09 TT
tox 68760, eath certificate be ex-	/sician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown  AMENDED 10/27/09 TT/5,16a-b, 20a-c, 22, per Fh g896 10/29/09 TT  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
cords, P. law requires th	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of qeath?  1  Yes 2  No 3  Probably 4  Unknown  24a. Was an autopsy performed?  1  Yes 2  No 3  Probably 4  Valunt own
Vital Recysician: The his certificate director, page	8	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Check only one)  1 Inpatient 2 ER/Outpatient 3 DOA  Other; 4 Nursing Home 5 Residence 6 ✓ Other: Scene
ision of Attending Phr death.	ertification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 X No  28d. Describe how injury occurred unk
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director:	0	Suicide 4 Homicide 4 Homicide  Found: private dwelling   General Specific   Found: private dwelling   General Specific   Genera
To the Hos within 24 h To the Fu	Medical	29b. Signature and title of certifier  29c. License number  October 11, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 6 2009  32. Registrar's Signature

09-07746 Ro

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onnie L. Myers		1- For State	ate of Maryl		artment of		and	Menta	al Hyg		og No	20	09	3413
Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)					-	2	. Date of Dea				ime of Death
ledical Examin		Ronnie L. Mye								Month October 5	Day 2009	Year	2	035 hrs
		4a. Facility Name (if not institutio	-	umber)	41	c. City, Tov		ocation of	Death			County of Dea	ith	
d		11 S. Walnut Street A				Hagers			2111	0.0 : 60:		ashington	inth of la	o Chata a
Funeral		5. Social Security Numbeunk		7. Age (In yrs.		If Under Months		If Under Hours	24Hrs. Min.			D/YYYY) 9. E Fore	eign	ulik
Director			1 X M 2 F	54	4 Yrs.					Ju1y	5, 19	955	Country	)
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Location	n							10d	. Inside City Limits
* · ·		,	ington		Hagerst								1 [	Yes 2 X No
Aaryland 28a-f show 1 at once,	흥	10e. Street and Number			IIIGOTO	10f. Zip C	ode			r	10g. Citize	en of What Co	untry?	21
th the Maryland 23a or 28a-f sho	Director	11 S. Walnut	Street #	305		2	1740	0		ŀ	USA	A		
with t	- 1	11. Marital Status U1		cedent Ever in U	J.S. 13. Was	Decedent	of Hispa	anic Origin	n? (Spe	cify Yes or N	0- 1	4. Race - Am		ndian, Black,
death r item	uneral	1 Never Married 2 M	arried Armed I	Forces?	dirk	s, specify		Mexican, F	Puerto R	ican, etc.)		White, etc.		
after al", o	by F		orced If Yes, Give You			Yes 2X		specify:				Specify: wh		
hours	ᄝᅵ	15. Decedent's Education (Spe			16a. Decedent during mo	's Usual O st of worki						nd of Busines	s/Indus	<sup>try</sup> unk
36 in 72 han "	plete	Elementary/Secondary (0-12)		(1-4 or 5+)							1			
5-0036 fled within 7. Hygiene. I other than	Comple	unk 17. Father's Name (First, Middle)	Last)			unk	. 18	3.Mother's	Name (	First, Middle,	Maiden S	Surname)	-	unk
11215-0036 Id be filed within 72 Aental Hygiene. narked other than '	a					diii								unk
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	은	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address	(Street	and Numb	er or Ru	ral Route Nu	ımber, Cit	y or Town, Sta	ate, Zip	Code)
and 2 shou lealth and N tem 27 is n traumatic		O.C.M.E.		Loo	111 P					more. Date	MD	21201 ocation - City	or Tow	n State
ore, ML es 1 and 2 s of Health at If item 27 her traums		20a. Method of Disposition  1 Burial 2 Cremation	n 3 Removal		crematory or oth		or cente	etery,		Date	200. L	ocation - City	01 1000	II, State
Fag. Pag. ment tant:		4 Donation 5 X Other S	pecify: in st	ate							⊥.			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:		21. Signature of Funeral Society Roll of Co.	S. Warde	Directo	or Sta	ame and A	nato	omy B	oard	655 V	V. Ba	1timor	e S	treet
Physician	$\dashv$	23a. Part Enter the disease, of	complications that	caused the deat	h. Do not enter th	timo e mode of	re dying, s	MD uch as ca	2120 rdiac or	respiratory a	rest, shoo	ck, or heart		pproximate Interval
/Medical		failure List only one cause	on each line.		xycodon								E	Between Onset and Death
xaminer		Immediate Ca se (Final disease or condition resulting in death)	u	a consequence										<u></u>
1		Sequentially list conditions,	b										+	
	ine	if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):									
d d	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):									
	dical E	X unpended	dAMENDED	23a,PI	.,27,28a	-1,pe	rME.	, g89	7 1	1/3/09	TT		+	
a e iii	edic			, 								. Date of deliv	/erv	
Box 68760, e death certificate b the attending physiced for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	ha I — '	s, outcome of pre birth		al death	3	Ectopic	pregnar	ісу		Month	Day	Year
ox 6  Ith cer  Ith ce	sicia		I T 🖃	gnant at time of o	death 5 Otl	ner (Speci	fy)				1			
he dea	Phys	Part II. Other significant condi	90114	nown	reculting in the U	ndorluina	auce ai	von in Par	+ 1	23e Did	tohaccou	ise contribute	to the	cause of death?
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d is after death.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	Ď										_			y 4 🗸 Unknown
ords, P.C. w requires that us been signed to should be deta	Completed	<u>Hypertensive</u>	atheros	crerorio	: cardio	vascu	Lar	alse	ase	24a. Wa	s an			sy findings available
COrc law re has be	nple									per	opsy formed?	death	?	oletion of cause of
Vital Rec ysician: The his certificate director, page	Ç	05.11	<del></del>			2	C Diago	of Death (	Chaolco		2 N	1 🗸	Yes	2 No
ital sician is cert	Be	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatient		10	Other <sub>4</sub>		Home 5	Reside	nce 6 🗸 O	ther: So	ene
ing Physic After this	. To	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Time of I			y at Work?		28d. Describ	e how inju	iry occurred		
ion (tending eath. A the fur	tion		ding Ed	nth, Day,Year)	Fd 8:30	mq C	1 Y	es 2X	No l	ınk				
VISI or Att fter de Directe	ifica	2 Accident Inve	Stigation	ace of Injury - At	home, farm, stree		office bu	uilding, etc	).	28f. Location	(Street a	nd Number or	Rural	Route Number, City
Division pital or At ours after deral Direct filled in by	Certification:	4 Homicide dete	ermined (Specif	y) re	esidence				/	Apt 30	5 Hag	gerstov	m,	MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I to the Finneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		10.100.101.	hysician: To the b	est of my knowle	edge, death occur	red at the	time, dat	te and pla	ce, and	due to the ca	use(s) an	d manner as s	stated.	ause(s)
Division To the Hospital or Attend within 24 hours after death. To the Finneral Director: completely filled in by the I	ledical		and manne	s or examination r stated.	and/or investigat			number	Julieu di	. are ame, ua		Date signed (		
	Σ	29b. Signature and title of certifi	, 11.		×	290.	O.C.N		OGME			ober 6, 20		
		Theodore.	M. K.	8 Ja.,	m )		5.0.1		- AINE					
_		30. Name and address of person Theodore M. King, Jr	,	ause of death (file stant Medical		111 Pe	nn Stre	eet, Bal	timore	e, MD 212	01			
St	ate	31 Date filed (Month, Day Year	32	Registrar's Signa										
Regist		OCT 26	2009 2	news ,	J. par	Con								

State of Maryland / Department of Health and Mental Hygiene 2009 34134 Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month

CUIDBER

3. Time of Death

2020

Year

4c. County of Death

2009

Phy	sici	an
/M	edi	cal
Exa	mir	ıer

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

CONSTANCE

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Modicel Extraigrational Language.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	JOHNS HOPKINS BAYVIE					LTIM							N/A	
	5. Social Security Number 6. S	Sex □M 2 TxtF	7. Age (In yrs. I	a <i>st birthd</i> ay) Yrs.	If Unde Months		If Under Hours	Min.	8. Date of Bi (Month, D			Cou	place <i>(State or Foreig</i> ntry) :vland	ın
	Usual Residence of Decedent		44						Feb. 1	. ۷ و ۱	903	Mar	yrand	_
	10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside City Limits	S
ģ	Maryland Balti	moro					Dund	alk					1 ☐ Yes 2 💢 No	Э
<u>e</u>	10e. Street and Number	more			10f. Zi	p Code	Dana	alk		10g. C	itizen of V	Vhat Cou	ntry?	
eral Directo	2814 Creston R	oad					2122	2		U:	nited	l Sta	ites	
	11. Marital Status	7	dent Ever in U.	S. 13.	Was Dece	edent of h	lispanic O	rigin? (Sp	pecify Yes or N Rican, etc.)	0-	14. Rac	e - Ameri k, White,	can Indian,	
T.	1 Never Married 2 Married	1 Tes	2 No	- 1	1 □ Yes		Specify		r noun, etc.)		Specify		etc.	
Completed by Fun	3 Widowed 4 Divorced	Year or Da	ates:							Т			White	_
ete	15. Decedent's Ed (Specify only highest gra	ducation a <i>d</i> e com <i>pleted)</i>		16a. Dece (Give	kind of wo	ork done	durina mo:	st of work	ing	16b.	Kind of Bu	usiness/Ir	ndustry	
E D	Elementary/Secondary (0-12)	College (1			gency		•	Toc	h		Ambu1	ance	· Co.	
ပ္သ	12 Years 17. Father's Name (First, Middle, Last,	2 Ye	ars	Emer	gency	y riec			e (First, Middle					_
o Be	Donald Cliffor		. Sr.						a Blanc					
ĭ	19a. Informant's Name/Relationship (		, 52.	19b. Mailii	ng Addres	s (Street	and Numb		ral Route Num					_
	John F. McFeater		and)	281	4 Cr	esto	n Roa	d D	undalk,	Ma	ry1ar	1d 21	.222	
	20a. Method of Disposition  ★□ Burial 2 □ Cremation 3 □	7 D 1 f 1	20b. P	lace of Dispo em <i>etery</i> , crei	osition (Na matory or	me of other pla	ce)		Date	20c.	Location -	City or T	own, State	
	4 □ Donation 5 □ Other (Specif		0a	k Lawn	Ceme	eter	у	10/2	6/2009	В	altin	nore,	Maryland	
	21. Signature of Funeral Service Licer	nsee )	L	- 2					Home o					
	(X/legon	C./Ce.		Danatan					undalk.		rylar	nd 21	Approximate	_
	23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on e	ach line.	i. Do not en	ter the mo	ide of dyl	ng, such a	s cardiac	orrespiratory	arrest,			Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)		PIRATORY		E_									
		Due to (	or as a consequ	LATORY	DISTOS	۲۲ ۲۰۰	LOBOLA	46						
er	Sequentially list conditions, if any, leading to immediate	b. ALUT Due to (	or as a consequ		V 13 114C	الا دد	אטאטרי	112						_
E L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	460	515											
Exa	that initiated events resulting in death) Last	U	or as a consequ	uence of):										
ca	•	d												
Ned	IE EEMALE.	-					-			-				
an/	IF FEMALE: 23b. Was decedent pregnant		come of pregna		☐ Ectopic	pregnanc	СУ					te of deli	very Day Year	
Sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregi 9 ☐ Unkn	nant at time of do	leath 5	Other (s	specify) _					IVIC	JIIIII	Day Tour	
Physician/Medical Examiner	Part II. Other significant conditions	contributing to de	eath hut not resu	ulting in the u	ınderlying	rausa niv	en in Part	1	23e Did	tobacco	use conf	tribute to	the cause of death?	_
þ	Tart II. Other significant conditions	contributing to de	Jan Dat Hot Tool	aning in the c	indonying	oudoo gii	ron mr r care						obably 4 Unknow	vn
Completed									24a. Wa				topsy findings availab	-
mp									aut	opsy formed?		prior to c death?	ompletion of cause or	f
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۲۰ To	27. Manper of Death	28a. Date	of Injury	28b. Time o		28c. Inju		aursing m	28d. Describe				ary)	_
<u>5</u>	1 ✓ Natural 5 ☐ Pending investigatio		th, Day, Year)	Injury	М		rk? ]Yes 2[	]No						
č	3 Suicide 6 Could not be determined	26e. Place	of Injury - At ho	me, farm, st	reet, facto	ry, office			28f. Location City or To			ber or Ru	ral Route Number,	
Cert	4 El Torriodo	Dona	rig, oto: (epoon						ony or r					
Medical Certification:	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	miner: On the b												
ž	29b. Signature and title of certifier				29	9c. Licen	se number			29d. [	Date signe	ed (Month	n, Day, Year)	
	Poll to Work					RES.	000			Ĉ	TOBEL	2 20	2009	
	30. Name and address of person who					AVE	NUG	BAI	TIMERZ	M	D 2	17.26	1	
е	31. Date filed (Month, Day, Year)		Registrar's Signa	ture &	1-	20		16	- sig trooping	* 1				
r	UU126	PAAA	enera.	Øx	STORM									

DHMH 17 Rev 1/2001

Registrar

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B. Sand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Charles O'Neal 2009 Hilliard 10 20 1:59 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto Towson Manor Care N/H If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-15-1945 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min **X**☐ M 2☐ F 246-70-3378 63 **Director** N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1x Yes 2□No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 906 Belgian Avenue Apt 1 C 21218 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) eard 2 should be filed within feath and Mental Hygiene.
n 27 is marked other than "n st traumatic event \*\*\* Elementary/Secondary (0-12) College (1-4or 5+ DaVita Dialysis Driver llth grade N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas O'Neal James Annie Payton Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau Sean O'Neal-Son 20 Ramsgate Ct Lansdown, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-27-09 Greenmount Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 14 1101 E. North Avenue Balto, Md 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage End /Medical Due to (or as a conse y ence of) **Examiner** 30 Stale conlex Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine melli his death certificate be executed Diabetes physician and is the burial-trans Due to (or as a consequence of): Box 68760, ension Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been siç r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?
Yes 2 No certificate has 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) ဥ within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manper of Death 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation Iniury 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 29a. Certifier 1 🖸 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 252749 10-21-2009

DHMH 17 Rev 1/2001

State Registrar TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Os lev

31. Date filed (Month, Day, Year)

Suste

32. Registrar's Signatur

509

J. HIRPADLA MO

09-08211 Kathleen Oppel

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 34136

			- For State Registrar		Certif	ficate of	Death			Re	g, No.	200	, ,	0410
	Physici	an/	Decedent's Name (First, Middle,L	.ast)			_			Date of Deat	n Dav	Year	3. Time o	
Medica	al Exami		Kathleen		qO	pel				October 22	2, 2009		1426	hrs
			4a. Facility Name (if not institution, Franklin Square Hospita			41	o. City, Town, o Rosedale	or Location of	Death			nty of Death		
					/le ure leet	hirthday	If Under 1 Ye	ar If Under	24Ure 1	R Date of Birt				ate or Foreign
	Funeral Director		220 52 5026		(In yrs. last	birthday)	Months Da		Min.			Co	ountry)	
	71100001	ļ		M 2XF	61	Yrs.				4-5-1	948	Ne	w Har	npshire
	any	}	Usual Residence of Decedent  10a. State 10b. County		10c. City. To	wn or Location	on .	_	-				10d. Insid	le City Limits
	_		MD		•	timor								es 2 No
	Maryland 28a-f show 1 at once.	흱	10e. Street and Number		Dai	CIMOL	10f. Zip Code			. 10	Da. Citizen o	f What Cou		
	e Mar or 28; ied at	Director	3522 Elmora A	wanua			21213			1"	U.S.		arti y .	
2	death with the Maryland or items 23a or 28a-f sho		11. Marital Status	12. Was Decedent	Fuer in II C	142 14/00	Decedent of H		n2 / Snac	ify Voc or No		Race - Amer	rican Indian	Black
3	ath w items	Funeral	1 Never Married 2 Marri	ied Armed Forces?	-		s, specify Cuba					Vhite, etc.	TCGIT IITGIGIT	, Didok,
			3 Widowed 4 X Divorce	1 Yes 2 ced If Yes, Give Year	X No		Yes 2 X N	o specify:			Spec	<sub>ifv:</sub> Wh	nite	
•	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	ā	15. Decedent's Education (Specify	or Dates:	pleted) 16		's Usual Occup		ind of wor	k done	16b. Kind o		/Industry	
	72 ho	ë	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	during mo	st of working lit	fe. DO NOT L	use retired	1)				
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2-0	led within Hygiene. other tha the Medic		17. Father's Name (First, Middle, La	•						irst, Middle, N				
21215-0036	wild be fil Mental F marked c event, i	å		orman		ipp		Stas				Dude		
2	유민		19a. Informant's Name/Relationship Angela Goligh				Address (Str							
MD	l and 2 s Health ar item 27		20a. Method of Disposition	- uau			tion (Name of c			Date		tion - City o		
J.e.	F F F		1 X Burial 2 Cremation	3 Removal from Sta	cre	matory or oth	er place)				İ	•		
Ξ̈	Pag ment lant; or of		4 Donation 5 Other Spec	cify:	Lak		Ceme			27-09	Syk	esvi.	lle,	Md.
Baltimore,	permit. Page Department Important; injury or otl		21. Signature of Funeral Service Lie				ame and Addre		JUS					F.H.
		3 00	23a. Part L. Enter tife disease, or co		U- d- U- D	26	3 S. (	Conkl	ing	St. E	alto	. Md		224 imate Interval
	ıysician Medical		failure. List only one cause or	n each line.										en Onset and Death
	aminer	- 1	Immediate Cause (Final disease or condition resulting in death)	a. Hypertens		theros	cleroti	c card	liova	scular.	disea	ase	-	Death
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	an an	Physician/Medical	X UNPENDED	AMENDED 23a	,27,pe	ermE, g	g896 10	/30/09	TT					
760,	ite be exe hysician a e burial -	Je d	IF FEMALE:	23c. If yes, outcon	ne of pregna	ncv					23d, Da	ite of delive	ry	
387	rtifica ling p	au	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death	B Ectopic	pregnand	су			Day	Year
Box 68	death certifi e attending for use as	Sici	1 Yes 2 No 9 V Unkno	Pregnant at	time of death	h 5 Oth	ner (Specify)							
m.	s that the de sned by the detached f	Ě	Part II. Other significant condition	9 Onknown	but not roce	ulting in the u	ndorlying cause	a aivan in Pa	rt I	23e Did to	bacco use	contribute t	o the cause	of death?
P.0	that med b detac	ρ	t are in other digitalions	is communing to death	, but not rest	atting in the di	nacrying coop	o giroii iii i			2 No			
S,	law requires t has been sign 2 should be c	ted							_	24a. Was				ings available
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Rec	The contract of the contract o	Completed								1 ✔ Yes		1 🗸		2 No
草	ysician: The l his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital:				Other,						
Division of Vital Records,	Physi er this ral dir	ဥ	1 Yes 2 No	ı inpatie		R/Outpatient		njury at Work		Home 5 8d. Describe	Residence		er:	
0	ding Phy 1. After th funeral	ᇹ	27. Manner of Death  1 X Natural 5 Pendin	28a. Date of Inju (Month, Day,Y	ear)	SD. Time of Ir	′ ′ I _	Yes 2	- 1	ou. Describe	now injury o	ccurred		
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ĭ	alor, safter al Dir	Certification:	3 Suicide 6 Could I		jury - At nom	ie, iarm, stree	et, factory, office	e building, etc	.	or Town, S		under or r	turai Roule	Number, City
	ospit hour unera ly fill	- 1	4 Homicide	(0,000.))		death consum	and at the time	data and nie	b ban on	ue to the sour	o(a) and ma	annor on ot-	atod	
	To the flospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death. within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ica	one) 2 ✓ Medical Exami	sician: To the best of my iner:On the basis of exam	mination and	, dealir occuri I/or investigati	ion, in my opini	on, death oc	curred at t	the time, date	and place, a	and due to	the cause(s	:)
		Medical	29b. Signature and title of certifier	and manner stated.				nse number				signed (M		
	8.		anetz				0.0	C.M.E.			Octobe	er 24, 200	09	
	h	ļ	30. Name and address of person w	ho completed cause of a	eath (Item ?	3a)								
OX	DG1,100			stant Medical Exam			treet, Baltir	nore, MD	21201					
- (	S	tate	31. Date filed (Month, Day Year)	32. Registra	r's Signature							_		
	Regis		III.I V.K.ZUUS	Therene ,	The state	es Alas								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 9:20 AM M October 21, <u>Lawson Oxendine</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown NMS Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 25, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 ₹ M 2 □ F Florida 1923 85 **Director** 267-26-0227 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt: If item 27 is marked other than "natural", or items 24 or 28a-f show unt; If other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 16513 Fairview Road 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ¶43-4 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 143-47 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) automotive 12 mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emidell Williams Lawrence Oxendine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Sheerer Drive Martinsburg, WV 25404 19a. Informant's Name/Relationship (Type. Print) Tina M. Myers/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signatule of Funeral Service Licensee Ronald S Wards 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10ML disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1∐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14014 MAISH oncordia

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

26

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
Character of Manufacial / Department of Ha	alth and Mantal Hustons

	1- For State Certific Registrar	ficate of Death	Reg	. <sub>No.</sub> 2009 3413				
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	ley	2. Date of Death Month October 23,	Day Year 0835 hrs				
	4a. Facility Name (if not institution, give street and number) 922 Mt. Carmel Road	4b. City, Town, or Location of I Parkton		4c. County of Death Baltimore County				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 X F 4 5	birthday) If Under 1 Year If Under 2  Months Days Hours  Yrs.	8. Date of Birth Min. March 6	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland				
lary and 28a-f show any Latonce. ector	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits           MD         Baltimore         Parkton         1 Yes 2 X No							
the Maryland as 28a-f sh outfied at once	10e. Street and Number 922 Mount Carmel Road	10f. Zip Code 21120		o. Citizen of What Country? United States				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced If Yes, Give Yeer	Was Decedent of Hispanic Origin     If Yes, specify Cuban, Mexican, F      Yes 2 X No specify:		14. Race - American Indian, Black, White, etc. Specify: White				
5-0036 ed within 72 hours aft tygiene. other than "natural" the Medical Examine Completed by	l or Dates:	6a. Decedent's Usual Occupation (Give kir during most of working life. DO NOT us		16b. Kind of Business/Industry				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE Comple	12 4 17. Father's Name (First, Middle, Last)	Credit Analyst		McCormick & Company  Maiden Surname)				
21215-00 uld be filed wit Mental Hygien marked other c event, the MI	Donald Joseph Hodnett		Bambi Diane B					
MD 21 d 2 should th and Me n 27 is ma tumatic ev	19a. Informant's Name/Relationship (Type, Print )  Bruce K. Polley — Spouse	19b. Mailing Address (Street and Number or Rural Route N 922 Mount Carrel Road, Parkton, I						
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumating	1 X Burial 2 Cremation 3 Removal from State Dula	ace of Disposition (Name of cemetery, ematory or other place)		20c. Location - City or Town, State Timonium, Maryland				
Baltimo permit. Page: Department o Important: I	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Evans Funeral Chapel & Cremation Services							
Physician	23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	16924 York Road, Moon on the enter the mode of dying, such as car	diac or respiratory arres	st, shock, or heart Approximate Interval Between Onset and				
/Medical xaminer	Death							
niner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause							
ransit Exam	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  X UNPENDED  IF FEMALE:  23c. If yes, outcome of pregnancy  Due to (or as a consequence of):  23d. Date of delivery							
0, be exerting a sician a burial - a edica								
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Exa	The part II. Other significant conditions  d							
P.O. Be that the de gned by the eleached f								
Vital Records, F sysician: The law requires in his certificate has been sign director, page 2 should be.  O Be Completed to	The law requires the la							
Recon The large page 2			perforr 1 ✓ Yes 2					
/ital /sician: /sician: /sician: /sician: /sician:	examiner?	26.Place of Death (C		Residence 6 🗸 Other: Scene				
ion of Vi tending Physi eath. tor: After this the funeral dir	Tes 2 110	28b. Time of Injury 28c. Injury at Work?		ow injury occurred				
Division o spital or Attending hours after death. neral Director: Aft y filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hos within 24 h To the Fur completely	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
_ / ≥	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 24, 2009				
OL Dend	30. Name and addies of person who completed cause of death (Item 2 Pamela E. Sputhall, MD Assistant Medical Exam	(3a)	ore, MD 21201	2., 200				
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Registral		ORIGINAL	00					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FH g896 10/26/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month 11:50 PM MARGARET 0 7.2 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Baltimore
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Peb. 5, Year 1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 1 F 75 215-30-1089 2009 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Director 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 S. Decker Street Funeral 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ♣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel mortant in other traumatic event, the Medical Evernina any injury or other traumatic event, the Medical Evernina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ρ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Brune Mary Ellen Brown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Kuzmiw/Friend 212 Margate Drive, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) f Fun al Service 22. Name and Address of Facilit Rendon-Bailey Funeral Home, P.A. /M00969 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncarrying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 5 Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 2 X No 1 □Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2′X No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director; A 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifier (Check only 2 | Mec. one) within 2 the

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

V, Sans

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00 32. Fegistrar's Signature,

29c. License number

R125-808

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 11=54PM Man 200° Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death 3415 Chapman Koad Randellstown Ba Himore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location Randall Stowr 10a. State 10b. County 10d. Inside City Limits ural", or items 23a or 28a-f sho I Examiner must be notified at hours after death with the Maryland Director Baltimone 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Chapman Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ 2 No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White "natural", 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Baltimore City Public Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Naoma Spilmer exol 19a. Infor t's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daxton H5 Road Randallstown MD 21133 Brother 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State tery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Baltimore, MD orraine 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee C. Greene Puneral SICS 22. Name and Address of Facility Vaughn landall Stown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or is a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ó Day Pregnant at time of death 5 Other (specify) s been signed by the same should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital မြ 2 ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death.

I Director: Af ed in by the fu Accident Investigation ☐ Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month. Day, Year) D 2511 2009 all 00 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) Suite 101 H DZIII

Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

20, crossroads

nue

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Rawat

32. Registrar's Signature

Barke

29c. License number

D0066515

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year Anthony William Sheppard Sr. 10 09 0657 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICS 12 3ULD SALISBURY POIONAL If Under 1 Year 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Days Hours Min 214 44 7213 64 **Director** March 12, 1945 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the fixedical Evant with ust be notified at Director Maryland Baltimore 1 ☐ Yes 2X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1031 Bayner Rd. 21221 death v Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Plato Everette Sheppard Mildred Catherine Noz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Sheppard (Wife) 1031 Bayner Rd. Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 10/26/2009 Baltimore, Maryland 21. Sig a ure of Funeral Service Li 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. OW 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 No 2 No 1 □ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ► ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 450497 23/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbur Dmycher 0.0 E Carroll St. 100 21801 31. Date filed (Month egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

09-07917 Ronda Shelton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onda	Shelton	1	State of Maryland / Department of He For State Certificate of De	alth and Mental Hyg ath	giene Reg. N	. 200	9 34141	
	Physicia		egistrar I. Decedent's Name (First, Middle,Last)	Date of Death		3. Time of Death 0245 hrs		
ledic	al Exami	ner	Ronda Shelton	Month Day October 12, 2	009 4c. County of Death			
			a. Facility Name (if not institution, give street and name of)	ty, Town, or Location of Death agerstown		Washington		
	Funeral Director		5. Social Security Number C. Soc	Under 1 Year If Under 24Hrs. onths Days Hours Min.	8. Date of Birth(M Sept_30	M/DD/YYYY) 9. Birt Foreig	hplace (State or California Intry)	
		-	Usual Residence of Decedent		Depe 30	,	10d. Inside City Limits	
	'any	Ī	10a. State 10b. County 10c. City, Town or Location				1 Yes 2 No	
	Aaryland 28a-f show 1 at once	ō	MD Washington Hagersto		10g (	Citizen of What Cour	2.2	
th the Maryland 23a or 28a-f sho notified at once			10e. Street and Number 12 S. Walnut Street #708 10f. Zip Code 21740			USA		
	5-UU30 Ited within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified at once the Medical Examiner must be notified at once	Funeral	11. Marital Status Unk 12. Was Decedent Ever in U.S. 13. Was De 14. Married 15. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 17. Was Decedent Eve	cedent of Hispanic Drigin? ( Spe pecify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,	
,	ifter de il", or ner m	by F.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:	140	Specify: wh	ite	
	5-UU.50 iled within 72 hours af Hygiene. I other than "natural the Medical Examin		during most of	sual Occupation (Give kind of w of working life. DO NOT use retir		b. King of Business/	maustry	
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	LILIO LILIO Duld be file Mental H marked ic event, t	To E	19a. Informant's Name/Relationship (Type, Print )	dress (Street and Number or F	Rural Route Number	r, City or Town, State	e, Zip Code)	
5	10re, IMID 2121 ages 1 and 2 should be fi nt of Health and Mental 1 it: If item 27 is marked other traumatic event,			enn Street Balt	imore, M	D 21201  Oc. Location - City o	Town, State	
	re, ML s 1 and 2 s f Health au If item 27 er traum:		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or other parts.		Date	oo. Loodiion ony o		
	Baltimore, permit. Pages I a Department of He Important: If it injury or other t		4 X Donation 5 Other Specify:					
3	Baltimo permit. Page Department Important: injury or ot			e and Address of Facility e Anatomy Boar		Baltimore	Street	
			Balt . Enter the disease, complications that caused the death. Do not enter the many complications that caused the death.	imore MD 212 node of dying, such as cardiac o	O 1 or respiratory arrest	shock, or heart	Approximate Interval	
	Physician Medical		failure List only one cause on each line.				Between Onset and Death	
	aminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injulies  Due to (or as a consequence of):					
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,						23d. Date of delive	ery	
	Records, P.O. Box 6876 The law requires that the death certificate care has been signed by the attending phy name 2 should be detached for use as the b	IF FEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1						
	× 68 th cert trendir r use a	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)					
1	Bo le deat the at	Physici	Yes 2 No 9 ✓ Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?	
	that the red by detach	) g	Part II. Other significant conditions contributing to death but not resulting in the difference of the conditions.	1 Yes	1 Yes 2 No 3 Probably 4 Unknown			
	S, F quires en sign	ted			24a. Was ar		autopsy findings available	
	Ord aw rec nas bee 2 show	l e			autopsy	ed? death		
	Rec The l	Completed	V	26.Place of Death (Check	1 Yes 2	No 1 🗸	res 2 No	
	25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only only)  27. Nursing Home 5 Residence 6 Other: Science of Death (Science of Death (Check only only))  28. Date of Injury 28. Injury at Work? 28d. Describe how injury occurred							
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	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.				28f. Location (St	28f. Location (Street and Number of Pural Route Number, City #708 own, State) 12 5. Wallingt St. #4708 own, MD		
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	Divis To the Hospital or A within 24 hours after To the Funeral Dire	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Variety)						
	To Witl	Med	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)			
1			IM The	O.C.M.E.		October 12, 20	)U9 	
			30. Name and address of person who completed cause of death (Item 23a)	Street, Baltimore, MD 2	21201			
	<u></u>		Dack Hido MB: Bopoty The Market					
	Reg	State istra	COT OC 2000	fled				

			For State	Sta	ite of Ma	aryland / [			nt of H e of D		nd M			009	31.	11.5
			Registrar  1. Decedent's Name (First, Middle	, Last)			Cert	uncat	e or L	eaur		2. Date of Dea	th		3. Time of	Death .
	Physicia		Anna	Ruth	S	pear						Month Octob	Day	Year 2009		
	Medic Examin		4a. Facility Name (if not institution			<u>+</u>		4b. City, Town, or Location of Death			OCCOD	4c. Coi	unty of Death		, 11	
	4		2217 Maple Ro	ad				Edgemere					Baltin	nore		
	Funeral		5. Social Security Number	6. Sex 1 \( \text{M} \) 2		(In yrs. last birti		If Unde	r 1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day	(Year)	9. Birth Ço <i>ui</i>	place (State o	r Foreign
	Director		219-16-6762 Usual Residence of Decedent		*	86	Yrs.					July 9	1923	Mar	yland	
	and show	or	10a. State 10b. County			10c. City, Town	or Loc	ation							10d. Inside Ci	ty Limits
	Maryla 18a-f	rect	Maryland	N/A					Balt	imore	Cit	у			1 🔀 Yes	2 🗌 No
	a or 2 be no	Maryland N/A  10c. City, To  Maryland N/A  10e. Street and Number  4316 Mainfield Ave.  11. Marital Status  12. Was Decedent Ever in U.S.							10f. Zip Code					10g. Citizen of What Co		
	h with	nera	4316 Mainfield	Ave.		6			212	214			Unite	ed Stai	tes	
	riten inerr		11. Marital Status	Arn	s Decedent Ev ned Forces?		13. W	/as Dece Yes, spe	dent of His cify Cubar	spanic Origir n, Mexican, I	n? (Spec Puerto F	cify Yes or No- Rican, etc.)		Race - Americ		
99	al", o	d by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	If Ye	Yes 2 <b>X</b> Nes, Give es, Give er or Dates.	No	1	☐ Yes	2 <b>X</b> No	Specify:			Specify: White			
ŏ	hours natur lical I	Completed		it's Education		16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind o	of Business In	dustry	
2	e. han ",	duc	(Specify only highe Elementary/Seconday (0-12)	1	lege (1-4 or 5+	+)	(Give ki life. DC	ind of wo NOT us	rk done di e retired)	uring most o	of workir	ng	Office of the			-
7	d with hygien ther ti	Be C	12 Years	<u></u>			S	ecre	tary					tes Att	corney	
Maryland 21215-0036	ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mertal Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 25 a or 28a-f show of ther traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, L	ast)						18. Mother		<i>(First, Middle, :</i> rriet L		,		
چ	ould by Me Me mark	Haward Lloyd    Haward Lloyd												Cadal		
Š	12 sh alth ar 27 is rrtrau		Leslie A. Melz		*	195	22	17 M	aple	Road	Ed	gemere,	Mary	Land	21219	İ
re,	1 and of Heg		20a. Method of Disposition			20b. Place of	Dispos	sition (Na	me of other place	,	D	ate	20c. Locati	ion - City or T	own, State	
<u>E</u>	Page nent ( ant: It ury or		1X Burial 2 ☐ Cremation 4 ☐ Denation 5 ☐ Other (S	3 ∐ Remova pecify)	al from State	Parkwo	od	Ceme	tery	$^{"}$ 1	0/2	6/2009	Balt	timore	, Maryl	Land
Baltimore,	permit. Page 1 Department of Important: If it any injury or o once.	21. Ignatur of Funeral Socice L	Du 22.	Name ai	nd Address	s of Facility Funera	al H	ome of	Dunda:	lk, In	с.					
1		V - V	23a. Part 1. Enter the disease, or	the death Do n		122 1	Vise	Ave.	Dur	idalk, I	Maryla	nd 212	22			
٠,		0 3	shock, or heart failure. List of Immediate Cause (Final	nly one cause	on each line.		01.01.01		io or aying	, 00011 00 00	41 (41)	/ copilatory and			Approximate Interval Bet Onset and I	ween
4	H <del>iysician</del> , Medical		disease or condition resulting in death)	a	oue to (or as a	co equence o	<b>~ ℃</b>					(	yru	1		
	Examiner		Consumation that are distance	<u>_</u>	·		,									
1.	- ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	ue to (or as a	consequence o	of):									
R	and transi	xan	Cause (Disease or linjury that initiated events	c	lua to (or oc o	consequence o	.n.									
_	ate be executed physician and the burial-transit	al E	resulting in death) Last	ا ا	de lo (oi as a	consequence o	,,,,									
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89	certifi inding use a	N/N	IF FEMALE: 23b. Was decedent pregnant		es, outcome of		۰. 🗆	F 4					23d.	Date of deliv	ery	
õ	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months?  1 Yes 2 No	4 🗆	Pregnant at t Unknown	PETAL death time of death		Other (s		/				Month	Day Y	⁄ear
O	t the by the	Phy	9 ☐ Unknown  Part II. Other significant condition			t mat vanislikin – li	- Ab	ب داد باد داد		:- D I		Tara and				
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/ita	/sicia s certi	To Be	examiner? 1 \sum Yes 2 \sum No	Hospital:	1 🗀 Inpatier	 nt 2 ☐ ER/Ou	teationt	3 🗆 D	Othe			ne 5 Resid	X-			
<del>o</del>	ig Phy ter this neral o		27. Manner of Death		Date of injury	/ 28b. T	ime of		28c. Injury	at	-	8d. Describe h			/	
o	endin eath. or: Aft he fur	1 Month, Day, Year) injury work? 2 Accident Investigation (Month, Day, Year) M 1 Yes 2 No														
Division of Vital Records, P.O. Box	or Att	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28. Date of injury (Month, Day, Year) 28b. Time of injury M 28b. Time of injury M 28b. Time of injury M 28b. Time of injury at work? 1 Lyes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										er,				
	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s															
	n 24 h	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										nner stated.				
	Vithii Vomp	-	29b. Signature and title of certifier					290	. License	number		2		gned (Month,		
			<u> </u>						D	371	33		10/	22/0	9	
	5		30. Name and address of person v	vho complete	d cause of dea	ath (Item 23a) (T	ype, Pri	int)	1100	-On	0	Hira	To	Da 11	10 21	204
¥	Stat		31. Date filed (Month, Day, Year)	0000	32. Registrar	's Signature	1	arko	9	F	~	9	1000	37/10	17 1	- J
	Registra		OCT 26	ZUU9	Jener	N B.	190	SLICO.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SALLY ANN STEINBERG 2009 /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center
5. Social Security Number | 6. Sex | 7 Ann (In use last hint) **Baltimore** Towson
If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 🗸 F 02/05/1919 215-03-1002 90 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evandary at 1XYes 2 □ No Director N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6106 PIMLICO ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. 1 Never Married 2 Married is marked other than "natural", or 1 □Yes 2 X No Specify: WHITE Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES MENS CLOTHING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LILLIAN CHARLES BRESSLER UNKNOWN ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 HUNTFIELD CT. GAMBRILLS, MD 21054 MARILYN LOWERY / DAUGHTER 20b. Place of Disposition (Name of LUBAW PT TO MUSACE POLACE) (NER TAMID) CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 10/23/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumoma **Physician** /Medical Due to (or as a consequence of): Examiner cholanon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tra Due to (or as a consequence of) as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by abeses 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 □Yes 2 12No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760 The law requires that the death certificate be Division of Vital Records, the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

completely filled in by the funeral director, within 24 hours after death.

To the Funeral Director: A

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Dentua Small lo

DO051347

29d. Date signed (Month, Day, Year) 1012210

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Cinast & St Town MD 21204 Cynthia Sociano

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Medical

09-07946	
Enrique Simi	s

nrio	que Simis		Sta	te of Maryl	and / Depa	artment o rtificate o	of Health	n and	Menta	l Hyg			201	0.0	3414
_	Physicia		Registrar  1. Decedent's Name (First, Middle,	Last)		Tillicate	Dealli				. Date of Death		201		of Death
Med	dical Exami	ner	ENRIQUE		NORBER <sup>-</sup>	Γ0		SIMI			Month October 13		ear		4 hrs
			<ol> <li>Facility Name (if not institution, Sinai Hospital</li> </ol>	give street and no	umber)		4b. City, Town, or Location of Death  Baltimore					4c. County of Death N/A			
	Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2		8. Date of Birtl	(MM/DD/YYY	Υ) 9. Bi	rthplace (	State or Foreign
	Director		220-90-9280	1 X M 2 F	į	57 Y	rs. Months	Days	Hours	Min.	12-23-1951 ARGE				INA
	ją.	ļ	Usual Residence of Decedent  10a. State 10b. County		Inc. City	, Town or Loc	ation							10d. Ins	side City Limits
	d now any e.		MD N/A			TIMORE								1 X	Yes 2 No
	th the Maryland 23a or 28a-f sho notified at once.	. O. L	10e. Street and Number				10f. Zip C	ode			10	g. Citizen of V	Vhat Cou	untry?	
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	ID 21 should and Me 27 is ma matic ev		19a. Informant's Name/Relationsh								ral Route Num				
	≥ g f g g g	-	SUSANA GROSBERG	/ 3131EK	20b	Place of Disp	osition (Nam			RUAI	Date OWIN	20c. Location	n - City c	r Town, S	111/
			1 X Burial 2 Cremation		from State	crematory or THELN	other place)	7 B.K	1	0_1	6-2009	DANDA	11 5 T	UMN	MD
	Baltimore, permit. Pages I as Department of He Important: If ite	1	4 Donation 5 Other Special 21/Sig ature of Funeral Service I	ecify; icansee	P	22	. Name and A	Address	of Facility	SOL	LEVINS	ON & B	ROTH	ERS.	INC.
	Per Per in		Michael B	uger							ROAD, P				
	Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	omplications that on each line.	caused the deat	h. Do not ente	r the mode of	dying, s	uch as car	diac or	respiratory arro	est, snock, or i	neart		een Onset and Death
	aminer		Immediate Cause (Final disease or condition resulting in death)	a. <u>Undet</u> Due to (or as	a consequence	of):				_				+	
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	760, ficate be g physici the buri	/Med	IF FEMALE: 23b. Was decedent pregnant in the		, outcome of pre	gnancy						23d. Date			Vee
	Box 68760 e death certificate the attending physical for use as the bu	sician/Me	past 12 months?	LIVE	birth gnant at time of o	death 5	Fetal death Other (Spec	3 <u> </u> ify)	Ectopic	pregnar	icy	Month	1	Day	Year
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	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Ď	Part II. Other significant condition	ons contributing	to death but not	resulting in th	ie underlying	cause gi	ven in Par	t I.		bacco use co ≥ 2 ✓ No	_		Unknown
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	tal Recionant The certificate ector, page	യ	25. Was case referred to medical				2		of Death (	Check c					
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	n of ding Ph. h. After t		27. Manner of Death  1 Natural 5 Pend	(Mor	e of Injury th, Day,Year)	28b. Time	of Injury  2		y at Work?		28d. Describe	now injury occ	urred U	ınk	
	or Attencather death Director:	icati	2 Accident Inves	tigation Unk	ace of Injury - At	home, farm, s	treet, factory,						mber or	Rural Rou	te Number, City
6	Divis pital or At ours after d eral Direct	Certification:	3 Suicide 6 X Could deter	not be mined (Specif						357	or Town, S unk	State)			
7	Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phone) 2 Medical Example 1	ysician: To the b	est of my knowle	edge, death or	curred at the	time, da	te and plac	ce, and	due to the cau	se(s) and man	ner as s	tated.	e(s)
$\subseteq$	To th To th comp	Medical	29b. Signature and title of certifie	and manner	stated.	and/or invest			e number			29d. Date s			
		~	Cal	7	4		-/-	O.C.1				October			
			30. Name and address of person	who completed ca	use of death (Ite							J			
				Assistant Med			enn Stree	t, Balti	more, N	1D 212	201				
	S <sup>.</sup> Regis		31. Date filed (Month, Day, Year)	Marca 32.	Registrar's Sign	A arkin	1								

OCME

09-08165	
Jose Villa	

08165		Please Type or Print in Black Indelible					
e Villa		State of Maryland / Department of Certificate of Ce		d Mental Hy		200	19 34 14
Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last)	or Death	<del></del> :	2. Date of Death		3. Time of Death
dical Exami		JOSE VIRGILIO VILLA			Month October 20	Day Year , 2009	1606 hrs
		4a. Facility Name (if not institution, give street and number)		Location of Death		4c. County of Death	
	Щ	Johns Hopkins Bayview Medical Center	Baltimore 1 Year	Millador 24Uro	le Date of Birth	N/A	thplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Day		10/11/1		untry) ADOR
<b>DG</b> O(G)		Usual Residence of Decedent	rs.		10/11/1	.572	ADOR
any		10a. State 10b. County 10c. City, Town or Local	ation				10d. Inside City Limits
and show nce.	ě	MD N/A BALTIMORE					1 X Yes 2 No
Maryl 28a-1	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Coul	ntry?
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ath wi	Funeral	1 Never Married 2 X Married Armed Forces? If	Vas Decedent of His Yes, specify Cubar			White, etc.	can Indian, Black,
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ours a atural camin	d by		ent's Usual Occupa most of working life			16b. Kind of Business/	Industry
6 n 72 h an "n kal E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)			,,,		
within giene.	Completed	6 SELI	FEMPLOYED	18.Mother's Name	First Middle M	CONSTRUC	TION
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	Be C	JOSE ALBERTO VILLA		ROSA MAT			
21; ould b d Men s mar	To		ing Address (Stre	et and Number or R	ural Route Numb	per, City or Town, State	e, Zip Code)
MD and 2 shallth an m 27 i						ORE, MD 21	
of Hez	Н	20a. Method of Disposition  1 Bunal 2 Cremation 3 X Removal from State Company of Table 1 ANA  4 Donation 5 Other Specify: DANTA ANA	osition (Name of ce other place)	Metery, UNKN	Date DWN		ZUAY ECUADOR
timent rtant:					TEG G B		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.						ZEILER & SC MORE, MD 21	
Physician		23a. Part I. Inter the diverse, or complications that caused the death. Do not enter fail or. List only of cause on each line.					Approximate Interval
/Medical		fair C. List only of cause on each line.  Immediate Cause (Final disease a. COmplications of ch	ronic alo	cohol abu	se		Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):					
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
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760, cate be physic he buri	Med	23a,27,perME,  IF FEMALE: 23c. If yes, outcome of pregnancy	g897 11	/17/09 TT		23d. Date of deliver	у
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tal Records cian: The law requi certificate has been ector, page 2 should	E O				1 Yes 2		es 2 No
tal cian: certifi	Be	25. Was case referred to medical examiner?  Hospital: 1 ✓ Inpatient 2 ER/Outpatie		e of Death (Check of Other 4 Nursing		Residence 6 Othe	
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ion C trending leath. tor: Af the fun	tion	1 X Natural 5 Pending (Month, Day, Yeer)	1	Yes 2 No			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicially filled in by the funeral director, page 2 should be detached for use as the burined buring.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, sti	treet, factory, office	building, etc.	28f. Location (S or Town, St		ural Route Number, City
Div Hospital of 24 hours ad Funeral D	Serti	4 Homicide determined (Specify)			OF TOWN, St		
		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occ (Check only one)  Medical Examiner:On the basis of examination and/or investig					
To the within 2 To the complet	Medical	2 Medical Examiner On the basis of examination ang/or investignation and manner stated.  29b. Signature and title of certifier	29c. Licen			29d. Date signed (Me	
	5	D-O Pall h		.M.E.		October 22, 200	
		30. Name and address of person who completed cause of death (Item 23a)					·
		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn S	treet, Baltimore	e, MD 21201	1	
St	ate	31. Date filed (Moath Day, Year) 32/ Registrar's Signature				•	

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 21, Physician/ 2009 Clifford Daniel Whipp, Sr. 1:13  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Months Washington DC 04/10/1936 **Director** 216-32-9676 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Baltimore Baltimore 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code Funeral 21220 2231 Old Eastern Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc.
White 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nr
any injury or other traumatic event, the Medis
once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchant Seaman Cargo Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Smith Amos Whipp 19a. Informant's Name/Relationship (Type, Print) Vicky Sladek/Daughter 19b. Mailing Address (Street and Number or Rural Route Number City or Town State, Zia Code) 2219 Hawthorne Road, Middle River, MD 21220 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ardent Cremation Services 1 Burial 2 X Cremation 3 Removal from State 10/23/2009 Hanover, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Ardent Cremation Services Zama C. Hardesty M01197 7522 Connelley Drive, Ste.N Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Tes 4 Nursing Home 5 Residence 6 Nother (Specify) 105 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Fractioner: To the best of my knowledge. diet the time. Sets and plane and due to the or 29b. Signature a address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles Wagner ĭ9, October 2009 5:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1321 Lafayette Avenue Gwynn Oak Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. 217-22-4979 Director 81 22, 1927 Oct. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Adical Event in a route to any injury or other traumatic event, Item Adical Event in a route to any injury or other traumatic event, Item Adical Event in a route of any injury or other traumatic event, Item Adical Event in a route of any injury or other traumatic event, Item Adical Event in a route of any injury or other traumatic event, Item Adical Event in a route of any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 926 Kent Avenue 21228 by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Supervisor <u>Telephone</u> 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Harry Wagner ္ရ Anna Moran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Daniel P. Wagner 4410 Van Buren Street; University Park, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park 4 □ Donation 5 □ Other (Specify) 10/24/2009 | Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwap Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral S LIC # MO1537 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction-Suspected disease or condition resulting in death) Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to increasing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerosis Years Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 Stroke, Aortic Aneurysm, 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia, Hypertension 24a, Was an has autopsy certificate perform 2 X No 1 ☐ Yes 2 ☐ No 1 □ Yes Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Home 2 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending Hospital or Attendi 24 hours after death, Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulloc daye Baltimore MD AVG 31. Date filed (Month, Day, Year) 32° Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### 09-07936 William Henry Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of He	ealth and Mental Hygie

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edical Exami	ner	William								October	12, 2	009		1925 hrs	
		4a. Facility Name (if no 3500 Block of					b. City, Town, Baltimore					4c. County o			
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the de	Physician	Part II. Other signific	ant conditions			esulting in the	underlying car	ıse given i	n Part I.	23e. I	Did toba	cco use conf	tribute to th	he cause of d	eath?
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To with	Mec	29b. Signature and ti		and manne	i stated.			cense nur						nth, Day, Year,	)
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		30. Name and addre	ss of person who				eet, Baltimo	ore, MD	21201			<del></del>			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 9:00 PM Ronald Michael Zamenski October 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3415 Noble Street Baltimore City N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ☑ M 2 □ F Hours Min. (Month, Day, Year) **Director** 043-74-4858 1966 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1x Yes 2 No Maryland Baltimore City ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3415 Noble Street 21224 <u>United States</u> within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o, δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. "natural" Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Air Conditioning & Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Mechanic 12 Years Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kathleen Janiski Zamenski Frank 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Kramer-Zamenski 3415 Noble Street Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Ht. of Jesus Cem. 10/24/2009 Dundalk, Maryland 21. Signalure of Funeral Service Ligensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 2 23a, art 1. Enter the dispute, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a constituence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 140850 October 22, 2009

Registrar
DHMH 17 Rev 7/2009

9103 Franklin Squae Drive

Baltimo MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OTTAVIAND MD

gistrar's Signature

VUNNE

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 16:18 PM 12 Shirley Gatchell Andrews October 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 E1kton 750 Nottingham Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2**XXX** Yrs Maryland 1937 July 6, Director 218-32-6846 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 1∩a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, If a Modical Extendent must be notified at 1 ☐ Yes 2 No Director E1kton Maryland | Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 750 Nottingham Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married 3altimore, Maryland 21215-0036 1 ∐Yes XXX No Specify Specify. White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospita1 <u>Purchasing Agent</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna McKinney ပ Earl Gatchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau 750 Nottingham Road, Elkton, Maryland B. James Andrews / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other pla Harford Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2009 Aberdeen, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one care a cardiac experience and line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or \*\* Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ sign I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate 1 ☐Yes 2 No 1 ☐ Yes Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampliner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check onl) one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) 111 West High Street, Suite 309, Elkton, Maryland John Mulvey, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bener B. parks

DHMH 17 Rev 1/2001

Registrar

17

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Hazel Dorothy Arnn ctobe 11,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince George's Lanham If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year Funeral Months Days Hours Min 1 □ M 2 🖾 F 578-26-6537 85 6/9/1924 Director Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examinat paracilish at 1 X Yes 2 □ No Director MD Prince George's Bladensburg death with the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5999 Emerson Street, Apt. 924 20710 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2∑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 72 hours after ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 21215-0036 1 □Yes 21 No Specify: ģ Specify: 3₺ Widowed 4 Divorced White Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) P.G. County Schools 11 Cafeteria Assistant Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o Richard Edward Windsor, I ပ Hazel Victoria Hutchson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17650 Amity Drive, Gaithersburg, MD 20877 Patricia Magruder/Daughter permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/13/09 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of), Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 robably 4 Unknown 1 ☐ Yes 2 No been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 certificate 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 60611 30 Name and 8118 Good Luck Rd., Lanham, MD. 20706 State Registrar

DHMH 17 Rev 1/2001

RND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Allen Reginald 1645 October 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Days 1 **X**M 2 □ F 578-80-2969 50 March 20,1959 Wash., DC Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Hyattsville PG10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 20782 5910 Chillumgate Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 \( \frac{1}{2}\)Yes 2 \( \triangle \)No \( \triangle \) If Yes, Give \( \frac{1}{2}\) 9 8 8 \( \triangle \)Year or Dates: \( \frac{2}{2}\) 0 0 1 Never Married 2 Married 1 ☐Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Post Office Mail Handler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jimmy Allen Elizabeth Yelverton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5910 Chillumgate Road
Hyattsville, Md. 20782 19a. Informant's Name/Relationship (Type, Print) Ronald Yelverton/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/14/09 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Hodges & Ec

3910 Silver Hill Rd., S

23a. Parrl. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate ause (Final disease or condition resulting in death)

a. Septic Shock Cheltenham, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death PANCREATIT Sequentially list conditions, if any, leading to fining solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIRATION Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADVANCED AMYOTROPHIC LATERAL SCLEROSIS 1 Tes 2 No 3 Probably 4 Unknown VENTILATOR DEPENDENT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 2 **2** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at

7 Is marked other traumatic event, II

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Department of Health as
Important: If item 27 Is
any injury or other trau
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1 and 2 should be Health and Mental

21215-0036

**Baltimore**, Maryland

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

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Completed

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Certification: To

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 ☐ Could not be

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requires that the death certificate be

Vital Records, Hospital or Attending Physician: The Division of after death. completely filled in by the 24 hours a To the I within 2 To the I

State

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 0056296 Name and address of person who completed cause of death (Item 23a) (Type, Print) AVre de GRACE, MO21078 MD 501 NION AVE DIRNDAUM 31. Date filed (Month, Day, Year) OCT 1 3 2009

28a. Date of Injury (Month, Day, Year)

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			1 - For Stete Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of I tificate of	Health and M Death		ene 2009	34156
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Thomas E. Ad	lams				Octobe		10:15A <sup>M</sup>
5	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Dea	th
			256 Possum Cour	t		Capito			Prince	Georges
	Funeral		5. Social Security Number 6. Sec			Months Days		8. Dete of Birth (Month, Day,	Year) Co	thplece (State or Foreign ountry)
	Director		577 – 74 – 2539		55 Yrs.			Sept.1	7,1954	Wash.,DC
	and w		10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
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	the 1	Director	10e, Street and Number		артсо	10f. Zip Code	105	10	g. Citizen of What C	ountry?
	ath with the Marylar 23a or 28a-f show ast be notified at	0	256 Possum Cour	+		20	743		United S	tatos
	after death with the Maryland or Items 23a or 28a-f show colner must be notified at	Funeral		12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of I	Hispanic Origin? (S)	pecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
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ğ	permit. Pages 1 Department of F Important: If Ite any injury or ot		1 XBurial 2 ☐ Cremation 3 ☐ F	lemoval from State	emetery, cren	natory or other pla		9/09	-1 1 1	
Saltimor	it. Partant		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>		vete	Name and Addr	emetery	l sanfo	<u>Chelte</u> nh Edwards	nam, Md.
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			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
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X Q	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal	Ideath 3	Ectopic pregnanc	Э		23d. Date of de Month	elivery Day Year
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	Phys rthis ral dir	T.	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	30 000	4 🗀 Mulang i	28d. Describe ho		<del>o</del> cny)
0	ding h. h. After tuner	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ]Yes 2∐No			
Division of	or Attending Physician: after death. Director: After this certific in by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str	eet, factory, office	)	28f. Location (Str City or Town	reet and Number or F	Rural Route Number,
á	afor after Dire	Certification:	4 Homicide	building, etc. (Specify	Y)			City of Town	, 3(4(4)	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	ai C	29a. Certifier 1 Certifying Phy	sician: To the best of my kno ner: On the basis of examina	wledge, death	occurred at the t	time, date and place	e, and due to the ca	use(s) and manner a	as stated.
	he Hu in 24 he Fu pletel	edicai	опе)	and manner stated.	orr and/or in					
	To t com	Σ	29b. Signature and title of certifier	20 20			nse number		d. Date signed (Mor	
	7 , ,		· Cynthia /	Million	200	HOC	58032	- 0	ctober	12,2009 1,00 2001k
0	3+1		30. Name and address of person who c			Print)	1 (1	\$31.0.1.	20: to	2 20 2001
			Cynthia M. L	Unllams I	30, 3	120 U	pron St	ww, un	Shinglor	1,00 2001k
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrars Signa	tarke	7				

es Arnold		State of Maryland / Department Certificate	nt of Health and Mental te of Death	Hygiene Reg. No	2009 341
Physicia	an/	Redistrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day	3. Time of Death
ical Exami	ner	JAMES ARNOLD  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	October 12, 20	lc. County of Death
		Prince Georges Hospital Center	Cheverly		Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		4Hrs. 8. Date of Birth(MN Min. 1/29/194	WDD/YYYY) 9. Birthplace (State or Foreign Wash. Country) DC
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits
* *	'n	DC Washi:	ngton		1 X Yes 2 No
ne Maryland or 28a-f show fied at once.	rect	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
ith the 23a or notifi	al Di	828 52nd Street NE  11. Marital Status	20019  13. Was Decedent of Hispanic Origin?		ited States  14. Race - American Indian, Black,
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fiealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho tran 27 is marked other than "natural", or items 43a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral Director	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Pu		White, etc.
	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Black
hours 'natur Exam	ted t		ecedent's Usual Occupation (Give kind uring most of working life. DO NOT use		, Kınd of Business/Industry
hin 72 te. than '	Completed		stodian		Metro
L13-0030 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		lame (First, Middle, Maide	
d be fi fental narked event,	o Be	Stokes Arnold  19a. Informant's Name/Relationship (Type, Print)  19b.	Annie  Mailing Address (Street and Numbe	Bell Robins	
MD 21 id 2 should ilth and Mei m 27 is mai	To	Leslie Danielle Arnold/Daughter 16	,		
e, R 1 and 1 Health Titem 1		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, ry or other place)	Date 200	c. Location - City or Town, State
MOFE Pages 1 nent of H ant: If i		1 Bullar 2 Paciernation 3 Removal nom state	ale Crematory   1	0/20/2009 R	iverdale, Maryland_
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygient Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		21. Licensee	22. Name and Address of Facility P	ope Funeral	Homes, P.A.
	_	23. Jan 1. Enter the divides, or complications that caused the death. Do not	15538 Marlboro Pi	ke Forestvil	11e, Maryland 20747 shock, or heart Approximate Interval
Physician /Medical		failure. List only one cause on each line.			Between Onset and
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxica Due to (or as a consequence of): Ca	rdiovascular dise	ase	nsive
	ŀ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause			
ecuted and transit	Еха	events resulting in death) Last  Due to (or as a consequence of):			
	edical	X UNPENDED	f,perME, g897 11/	6/09 TT	
760, cate be ex physiciar the burial		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box 68761 death certificate the attending phy ed for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic p	regnancy	Month Day Year
<b>Accords, P.O. Box 68/6</b> The law requires that the death certificate cate has been signed by the attending phyapage 2 should be detached for use as the b	Physi	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. s that the gned by e detach	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part		co use contribute to the cause of death?  No 3 Probably 4 V Unknown
rds, P.C requires that been signed I hould be deta	ted			24a, Was an	24b. Were autopsy findings available
Kecords, The law requireficate has been so	Completed		<u> </u>	autopsy performed	
tal Ke tian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (C	1 Yes 2	No 1 Yes 2 No
Vital  hysician: this certi	o Be	eyaminer?			idence 6 Other:
ing Phy After th	n: 7	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T	Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred
ttendi leath. tor: / the fi	atio	Natural 5 Pending Fd 10/12/09 Fd	1:30 pm 1 Yes 2 X N		
DIVISION tal or Attendi rs after death. al Director: // led in by the fi	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, far	rm, street, factory, office building, etc.	28f. Location (Stree or Town, State	et and Number or Rural Route Number City )4100 Ames St, N.E. n, DC
lospits t hours innera	20	29a. Certifier A Continue Physician: To the best of my knowledge dea	th occurred at the time, date and place		
UNUSION OF VITAL For the Hospital or Attending Physician: within 24 hours after death. To the Finneral Director: After this certifit completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date and	place, and due to the cause(s)
F W T CO	Me	29b. Signature and title of certifier	29c. License number		od. Date signed (Month, Day, Year)
		my us. wo	O.C.M.E.		October 13, 2009
1		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn	Street Baltimore MD 2120	1	
-	tate	CA Data Flori (M. M. Davi Varan) 6 20 Begintrot's Cignoture		•	
Regis		OCT 2 0 2009 Seme B. Da	uki		
Vint 17 Rev 1/2	20€T	(I) ATT	IGINAL.	0	CME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d & Pt II per phys. G896 10/26/09 dk
State of Maryland Department of Health and Mental Hygien 2009 34158 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 355PM 29 2009 **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Center Golden 10ing Jestm SH If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day) 9. Birthplace (State or Foreign Country)
Illinois 6. Sex-7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Months 229.52.8711 10 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r then "naturel", or Items 23a or 28a-f shov It e Medical Examiner must be notified at 1 ☑Yes 2 ☐ No MT Completed by Funeral Director estmm ste arroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21157 12341 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Importent: If item 27 Is marked other th any injury or other treumatic event, Illia once. homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ralph Merwin Burdick Elaine Donaldson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Avadikian/son 2849 Albert Rill Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) pirector 21. Signature Funeral Pryice Licensee Rotal Ld S . Wale 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part l Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UMOUN SVaIN Priysician months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bipolar disorder, COPD, High Blood Pressure 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Obesity, Diabetes, Gout, Metabolic Syndrome certificate has b irector, page 2 st autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0052035 September 30, 2009

Registrar

DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

291 Stoner

32. Registrar's Signature

Westminster MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hourso

OCT 26 2009

31. Date filed (Month, Day, Year)

Wayne A. Bowser

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

K UNK		St - For State tegistrar	ate of Maryla		ment of ficate of		Mental H	Re	eg. No. 2	009 3415	
Physicia	n/	<ol> <li>Decedent's Name (First, Midd</li> </ol>	le,Last) A. BOWSER					2. Date of Deat Month October 2.	Day Year	3. Time of Death 1006 hrs	
dical Examin		4a. Facility Name (if not institution		mber)	4	b. City, Town, or L	ocation of Deat		4c. County of De	eath	
	н	Rt. 40 and 715				Aberdeen			Harford	Bi-th-loss (State of	
Funeral Director		5. Social Security Number 216–66–9491	6. Sex	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mi		Fo	Birthplace (State or reign MARYLAND Country)	
<b>»</b> :	F	Usual Residence of Decedent  10a. State 10b. County		10c. City. To	own or Locati	on			10d. Inside City Limits		
d now any	. 1		IARFORD	, .			ERDEEN		1 X Yes 2 No		
arylan 8a-f st at onc	. O. L	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What 0	Country?	
vith the Maryland s 23a or 28a-f show s notified at once.		40 E. BEL AIR	R AVENUE,	APT 6		2100			UNITED S		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If viem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Married Armed F	2 X No	If Y	s Decedent of Hispes, specify Cuban,	Mexican, Puer	Specify Yes or No to Rican, etc.)	wnite, et	FRICAN	
s after rral",	à	3 X Widowed 4 Di  15. Decedent's Education (Sp	vorced If Yes, Give Ye or Dates:			Yes 2 X No		f work done	16b. Kind of Busine	AMERICAN ess/Industry	
2 hour "natu	ed	Elementary/Secondary (0-12		1-4 or 5+)	during m	ost of working life.	DO NOT use re	etired)			
5-0036 iled within 7. Hygiene. I other than	Completed	10				MASON		(m)		TRUCTION	
15-0 filed w Hygic d othe		17. Father's Name (First, Middle GEORGE BOWSEI					18.Mother's Nar HTLDA	•	Maiden Surname)		
2121 ould be fil Mental H marked ic event,	o Be	19a. Informant's Name/Relation	ship (Type, Print )		19b. Mailing	Address (Street	t and Number o	r Rural Route Nu	mber, City or Town, S	State, Zip Code)	
MD and 2 short and m 27 is aumatic		HILDA R. BOWSEI	R / MOTHER						ABERDEEN  20c. Location - Ci	, MD 21001	
s land of Heal If item		20a. Method of Disposition  1 X Burial 2 Crematic	on 3 Removal	rom State cr	ematory or ot			Date			
Baltimore, permit. Pages I an Department of Hea Important: If iter mjury or other tr		4 Donation 5 Other	Specify:	В		CEMETER:		0/12/09	DARLIN	GTON, MD	
Ball permit Depart Impor injury		21. Signature of Funeral Service	e Licensee	me' -	22.1	LISA S	COTT FU	JNERAL H	OME, P.A. VRE DE GRA	ACE, MD 21078	
Physician		23a. Part I. Enter the disease, of failure. List only one caus	or complications that	caused the death.	Do not enter t	he mode of dying,	such as cardia	c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and	
(Medical aminer		Immediate Cause (Final diseas	se a. <u>Drowni</u>							Death	
and the		or condition resulting in death)	Due to (or as	a consequence of)	):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		a consequence of	):						
	Examine	(Disease or injury that initiated events resulting in death) Las	Due to (or or	a consequence of	):	<del></del>					
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), be es siciar urial	edical	X UNPENDED	AMENDED						23d. Date of de	elivery	
Sox 68760 death certificate be attending physid for use as the bu	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live	, outcome of pregn birth	2 F	Fetal death 3 Ectopic pregnancy Mo				Day Year	
Box 6 e death cer the attendi	sicia		later aven	gnant at time of dea nown	ath 5 C	ther (Specify)					
ന യ ക്യ		Part II. Other significant con-		to death but not re	esulting in the	underlying cause	given in Part I.			ute to the cause of death?	
(ecords, P.O. I The law requires that the ate has been signed by the	d by							-	'es 2 ✓ No 3		
ords w requi s been should	olete								opsy pri	ere autopsy findings available or to completion of cause of leath?	
of Vital Records, ing Physician: The law require there this certificate has been simmed director, page 2 should be	Completed							1 🗸 Yes	The state of the s	Yes 2 No	
ician: s certifi rector,	Be	25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpatier		Other Nu	rsing Home 5	Residence 6	Other: Scene	
of Vi ing Physi After this funeral dir	<u>ا</u>	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Time of		ury at Work?	28d. Describ	e how injury occurre		
<b>-</b> = ∴ =	tion		ending Fd 1	0/2/09	Fd 10:	03 anh 🗀	Yes 2 X No		ct drowned		
Division of Vital Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certif Funeral director, publication by the funeral director,	Certification:	3 Suicide 6 C	ould not be etermined (Special	ace of Injury - At ho		eet, factory, office	building, etc.	Aberde	(Street and Number State) RE 40 Sen, MD	or Rural Route Number, City	
Fig. 10/2/09 Fd 10:03 ath a suicide and Number or Rural Route (Specify) and manner as stated.  2  Accident 3  Suicide 4  Homicide 22a. Certifier 1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									as stated.		
To t With To t	Medical	29b. Signature and title of cer	and manne	r stated.			se number			d (Month, Day, Year)	
		Upula 1	medbull			0.0	.M.E.		October 3, 2	2009	
		30. Name and address of pers				Penn Street, E	Raltimore N	AD 21201			
		Margarita Korell MD 31. Date filed (Month, Day, Ye		ledical Examir Registrar's Signati							
Regi	State stra	4		men 1	10 1	Wed_					
DHMH 17 Rev 1	/2001	301			ORIGIN	AL			000	ALC:	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** Richard Bustin October 8, 2:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1117 Meurilee Lane Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 112-16-5991 83 25, California Jan. 1926 Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show oldal Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1117 Meurilee Lane 20901 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: 9 Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Printer Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked ofth any lightly or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Bustin Clella Neher ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Bustin/Wife 1117 Meurilee Lane, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Oct. 2009 29, 1 Rurial 2 Cremation 3 Removal from State Arlington National Arlington, Virginia 4 □ Donation 5 □ Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage 3-B Non Small-Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy e Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate h 2 🗆 No 1 ☐ Yes 2x No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 ☐ Yes 2 ☐xNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide \*Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

parket

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Robert H. Gerard, MD

31. Date filed (Month, Day, Year)

OCT

D55522

1500 Forest Glen Road, Silver Spring, MD 20910

October 8, 2009

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 9, 2009 year Paul Laurence Bloom 3:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, May 14, 1 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours Min 1**X** M 2□ F Months 230-46-3636 70 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event. The Marchall Event. 10d. Inside City Limits 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 🂢 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Willard Avenue, #1203 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tessler Clifton Bloom Claire ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie A. Bloom, wife 4701 Willard Ave., #1203 Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 5 ☐ Other (Specify) King David Mem. Gdn. | 10/12/2009 | Falls Church, Virginia 21. Signature of uneral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failue. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖔 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe After this certificate funeral director, pag 1 □ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 10ther (Specify) HOSpice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) KOUATCHOU , MI D63748 October 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 13 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:06 am Irene Brownlee Erma toher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Plata Medica a ark If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Oct. 27, Social Security Number 7. Age (In yrs. last birthday, **Funeral** 90 Days 1 □ M 2XXF 245-14-8600 North Carolina Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2XX No Upper Marlboro Director Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number LISA 12402 Old Colony Drive 20772 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ∐Yes 2XXX No laryland 21215-0036 If Yes, Give Year or Dates: 1∐Yes 2**1∑1**No Specify. Completed by Specify: 3 Widowed 4 ☐ Divorced Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Industry Home Health Aide 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alston 4 1 1 Thompson Hooker Eliza or other traumatic ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a. Important: If item 27 is any Injury or other trau once. 12402 Old Colony Drive Upper Marlboro, Maryland Tonya L. Cowan / Grandaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition xxxBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2009 Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Licensee George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ship, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown ģ cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 □Yes 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**X**ÎNo 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, State

Registrar

OCT 1 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / O Physician AECHL 0320M RIC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 08/05/1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2□F Months Days Hours Min Guatemala 077-40-1143 67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If we Medical Examinal must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Directo Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4263 Sam Hill Court 21771 United States Funeral 12. Was Decedent Ever in U.S. Agmed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Specify: Guatemalan 1X Yes 2 □ No ğ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Federico Carlos Baechli Ofelia Aburez ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorge Baechli/Son 1222 Breckenridge Circle, Riva, Maryland 21140 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 10/03/2009 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 21. Signature of Fluneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mark 2973 Solomons Island Road, Edgewater,MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to infine lide cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Starto (ur as a consequence of) physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 **□**/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? certificate 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the

29a. Certifier

Medical

	<i>i</i>
Name and address of person who completed cause of death (Item 23a) (Type, Print)  NICHAEL J. LG FENTA W 145	MDZ14
1. Date filed (Month, Day, Year) 32. Registrar's Signature	

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

and manner stated.

Klnow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1315 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1201 Forked Creek Road Arnold Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye) Feb. 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Year. 1 □ M 2 🗷 F 213–36–2563 68 Yrs. North Carolina Director 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Arnold 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Forked Creek Road 21012 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner cours. "natural", or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10 \end{array}$ College (1-4or 5+) Waitress/ Homemaker Restaurant/ Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James J. Teaque Katie A. Reese ၉ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
1201 Forked Creek Arnold, MD 21012 19a. Informant's Name/Relationship (Type. Print) Jim Webber, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 06. 1 XBurial 2 ☐ Cremation 3 X Removal from State Lakeview Cemetery Blackstone, VA 2009 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service License P.A. Severna Park Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence x) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and strans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 st perform 2 No 1 ☐ Yes 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

HAN

Registrar

State

31. Date filed (Month, Day, Year) 0CT 06 2009

32. Pegistrar's Signature

who completed cause of death (item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

HQ A

Box 68760,

P.0.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Russell Wayne Bishop 2009 10:05 A™ October | 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Yrs 9/9/1943 Director 214-40-2750 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2X No Maryland Anne Arundel Millersville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 558 Brightwood Rd. 21108 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2X Married 2 No 21215-0036 1 ☐ Yes 2 🛛 No ρ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director of Printing US Naval Academy 12th of Health and Mental Hygid If item 27 is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Higgs Claude Bishop ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D partment of Health Important: If Item 27 any Injury or other tra Sandra K. Bishop/ Wife 558 Brightwood Rd., Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemeterv 10-10-09 Davidsonville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home MINULLA 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multipk **Physician** myeloma 4.5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ě 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 2 **V**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Inpatien 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 052830 anine Vernin 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Best gate Road # 300, Amapolis, ND 21401 Wernering, 900 Manine

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Box 68760.

P.0.

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 34167 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARY LUCILLE BENSON 1:50 A M SEPT 30, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MILLINGTON KENT 314 RACE ST. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 1 □ M 2 □ XF Months Days Hours 222-10-8681 Director 89 11/13/1919 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director MDKENT MILLINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 RACE ST. 21651 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify ģ Specify: 3 Widowed 4 □ Divorced Year or Dates **BLACK** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, The ORGE. SEAMSTRESS MANUFACTURING 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) DENNIS CLARK, SR. ပ GRACE BRATCHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNESTINE GRAVES/GREAT NIECE PO BOX 375 MILLINGTON, MD 21651 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PLEASANT CEMETERY 10/5/2009 PONDTOWN, MD 21. Signature of Funeral Service Licenses Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 W. CYPRESS ST. MILLINGTON, MD 21651 Krik & enbein 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of s that caused the se on each line. death. Do not enter the mode of dy Approximate Interval Between ng, such as cardiac or respiratory arrest. and Death Immediate Cause (Final **Physician** Cancer VOVdisease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery atte in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? yes 2 X No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 
Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident s after dean. ral Director: Aftr 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated ature and title of certifier 29d. Date signed (Month, Day, Year) an M.O Name and address of person who comp leted cause of death (Item 23a) (Type, Print) mJ 9M11 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER Day 3 2009 **Physician** ROBERT 4:55a M HAROLD BROWN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Laurelwood Nursing Home Elkton Cecil 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 6 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2 □ F 217-20-3887 84 1925 Maryland Director Usual Residence of Decedent the Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Cecil MD Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If then 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Walfaal Experience. 172 Center St. Apt. 6C 21913 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No 1943 If Yes, Give Year or Dates: −1946 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2X No White Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Marina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Harold Brown, Sr. Mary Paris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C.M. Brown (son) 1170A Milo Circle Lafayette, CO. 80026 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 DCremation 3 ☐ Removal from State Kent Cremation 10/14/09 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service License 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech
118 West Cross St. Galena, MD. 21635 M00510 23a Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 □ Yes 2 □ No. 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 certificate has autopsy performed? Yes 2 No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1. Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide To the Hospital e Funeral 29a, Certifier referrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1300709 1)54073 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) Newark DE 19713 Arion STONE te lot OLE CONTURAL DA 31. Date filed (Month, Day, 32. Registr State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day OCTOBER 6, ROBERT CALVIN BARKER 2009 10:55 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHESTERTOWN KENT CHESTER RIVER MANOR 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours 173-07-0111 Director 98 11/22/1910 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho Director 1 XYes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Funeral 8630 MT. HOPE RD 21620 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 □Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ XNo Specify. 9 Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MECHANIC AUTO/HVAC is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental HERBERT CALVIN BARKER HELEN SHOEMAKER THORPE traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai KENNETH C. BARKER/SON 349 IRON LAKE DR., EXTON, PA 19341 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 10/8/09 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed and Due to (or as a consequence of): Box 68760, certificate be Physician/Medical the attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death ☐Yes 2☐No 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DM မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of Certification: After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending ithin 24 hours after death.

• the Funeral Director; A

• ompletely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms Chartneton Md. 516 Was hing than 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	cation				11	0d. Inside City Limits	
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Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationsh		19b. Mailin	g Address (Street a		ral Route Number, City or Town, State, Zip Code)					
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ñ	an in De		Todal	M		CU	JRRAN-BROMV	VELL FUNERAL	HOME, P.A.,	308 HIGH S	T., CAMI	BRIDGE, MD 21613	
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8	0 m Cl	Completed	24a. Was an autopsy performed? 1 □ Yes 2 ♥ No								psy findings available mpletion of cause of 2 No		
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DIVISION	lo the hospital of Attending Priystician: The within 24 hours after death.  To the Funeral Director, After this certificate he completely filled in by the funeral director, page:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)								er or Rura	al Route Number,	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** OCTOBER 17 2009 LOVINE PETERS BELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CIVISTA MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 2 Manth, Day Year 2 - 8 - 1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** TEXAS Months Days 1 □ M 2**½** F 101 467-01-1081 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medient Examiner must be notitied at CHARLES LA PLATA MD. 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10200 LA PLATA ROAD 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give X Ye ar or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: BLACK <u>ک</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland 2121 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE SALESPERSON REAL ESTATE CO. 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental ADELINE PETERS JOHN PETERS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 Is any injury or other trauonce. 11080 WEYMOUTH CT. WILLIE GEROLD-DAUGHTER WALDORF, MD. 20603 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAND CEMETERY 10-21-09 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) permit. M00479 21. Signature of Funeral Service Licensee me and Address of Eachling MOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 X No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death le Funeral Director: / 2 Accident 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the I

State Registrar 29b. Signature and title of ce tifier

31. Date filed (Month, Day, Year)

nM

ABBAS OMAIS, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

7C POST OFFICE RD.

**ORIGINAL** 

29c. License number 05105

WALDORF, MD. 20602

29d. Date signed (Month, Day, Year)

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				f Maryland / Dep	artment of Health and rtificate of Death			34172	
			Registrar  1. Decedent's Name (First, Middle, Last)		Timcale of Dealit	2. Date of Death	. No.	3. Time of Death	
	Physici	ian		lerin Desame		Month	Day Year		
Vic.	/Medi		William Ed		T.: 1. 1		18 2009	8:35 A <sup>M</sup>	
1	Examir	ner	4a. Facility Name (If not institution, give street and nul	mber)	4b. City, Town, or Location of Dea	th	4c. County of Death		
	<u></u>		1310 Hicks Road  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	White Hall	8. Date of Birth	Baltime		
	Funeral Director		217-26-3109 1XM 2DF	82 Yrs.	Months Days Hours Mir	(Month, Day, Y	L927 Ma	place (State or Foreign intry) rvland	
			Usual Residence of Decedent			1109. 37 1	1727	Lylana	
	yland		10a. State 10b. County	10c. City, Town or L	ocation			10d, Inside City Limits	
	Mar B-f st	tor	MD Baltimore	White	Hall			1 ☐ Yes 2 💆 No	
	or 28	ire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	intry?	
	23a c	Funeral Director	17909 Big Falls Ro	ad	21161		U.S.A	Α.	
	dea	ner	11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White		
9	or h	E	1 X Never Married 2 ☐ Married 1 X Yes	2□No 1950-	1 ☐ Yes 2 X No Specify:	10 110011, 010.7	0		
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or D	ates: 1952			Wh	ite	
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12	within lene. then	m m	Elementary/Secondary (0-12) College (	1-40r5+)	ruck Driver		Construc	4+ i on	
	filed within 72 hours after death with the Maryland Hygiene. ither then "natural", or Herns 23a or 28a-1 show ont, the Medical Examiner niust be notified at		11 17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		CTOIL	
anc	a ta b	Be							
Ž	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show armetic event, the Madicial Examiner man be notified as	<sup>L</sup> O	Edwin Mays Burns  19a. Informant's Name/Relationship (Type, Print)	10h Mail	ing Address (Street and Number or F	en Eliza		in Code)	
Maryland	d 2 sho th and 7 ls ma traum		Eileen Larrick / S		.310 Hicks Road		Hall, MD		
	permit. Pages 1 and 2 should Department of Health and Mer Important; If Item 27 Is merke any injury or other traumatic <u>once.</u>		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		c. Location - City or T		
3altimore,	Pages nent of I		1 X Burial 2 ☐ Cremation 3 ☐ Removal from	State Dulanes	v Vallev Oc	t. 22,	·		
	permit. Pag Department Important; I Iny injury o	<	*4 □Donation 5 □ Other (Specify)  21 Signature of Funer Il Sarvice License4	Memoria	y Valley al Gardens 2. Name and Address of Facility J		Timonium		
Ba	permit. Departr Importa any inje		Daupal Harten	doin III	24 Second St.				
	寄		23a. Part1. Enter the disease, or complications that of	aused the death. Do not en				Approximate	
×.	9 *		shock, or heart failure. List only one cause on a	each line.	P	1	1	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	(or as a consequence of):	Cancar Ele	ing mela	Maria	14	
集	Examiner			(or as a consequence or).	00,-000-1			7-10-	
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8760,	cate be executed obysician and the burial-transit	dicai	d						
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Records,	law las b	ompleted	Cx protete			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of	
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		The second secon	ath (Check only one)			
of	sir dij	2	A	npatient 2 ER/Outpatre			e 6 ☐Other (Spec	ify)	
	ing F	inol	1 Marcial 2 1 ending	of Injury 28b. Time of Injury Injury	Work?	28d. Describe how	injury occurred		
Sig	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 280 Block	-A february A harver of the second	M 1 Yes 2 No	00/ 1 1/2 / (01/2)	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
=	tal or Attending Pi s after death. al Director: After the ed in by the funera	Certification:	determined 286. Place	of Injury - At home, farm, st ng, etc. (Specify)	reet, factory, office	City or Town, S	at and Number or Rui State)	ai Houte Number,	
Result	spital ours a leral		29a. Certifier 1 Certifying Physician: To the	best of my knowledge deat	h occurred at the time, date and place	e and due to the serve	co(e) and marcor co	stated	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	edical	(Check only 2 Medical Examiner: On the bi	asis of examination and/or in ner stated.	n occurred at the time, date and place ivestigation, in my opinion, death occ	urred at the time, date	and place, and due	to the cause(s)	
	ompl	Me	29b. Signature and title of gertifier		29c. License number	29d.	. Date signed (Month	, Day, Year)	
	~ > P O		VMul XIDAIN	Mas	019150		10/17/	) 4	
			30. Name and address of person who or mpleted cause	e of death (Item 23a) (Type.	Print)			v MD2111	
			30. Name and address of person who ompleted cause	MN MD	1/6921 90	MK RD	MONICTO,	N MD2111	

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 6, Day 2009 Year **Physician** Adele Rene Colfelt 5:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health and Rehabilitation Center Montgomery Wheaton 8. Date of Birth (Month, Day Year) Aug. 18,1910 5. Social Security Number 113–09–1651 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1 M 2 TF Months Days Hours 99 Director France Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MD Montgomery Silver Spring Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 1131 University Blvd. W. #416 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Xa Yes 2 □ No If Yes, Give WW II Year or Dates! W II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be G. Jackman Bettia Segal 2 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number of Bural Floute, Number, City or Town, State, Zip Code)
31 University Blyd W #416
Lver Spring, MD 20902 ໃງ31"ປົງ Silver Barry Colfelt/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University Medical Center 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 ☑Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service License 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any healing to inner flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed hed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 No 2 No 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 217 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director; filled in by the 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only and manner stated. To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person w io completed cause of death (Item 23a) (Type, Print) 31. Date filed (Months I) State Registrar

	_ For	Type or State o	Print in B	l / Depa	rtmen	t of H	ealth a	ire Al and N	II Copies Iental Hy	Are L giene	egible.	34174
	1 - State Registrar  1. Decedent's Name (First, Middle, Las Thanh-Dung Cohn	t)		Cer	tificat	e of L	Death		2. Date of Dec	Reg. No.		3. Time of Death 1105 P M
	4a. Facility Name (If not institution, give				Gai	ther	Location of				County of Death	ery
	5. Social Security Number 6. Social Security Number 1  578-90-6073 1  Usual Residence of Decedent	ex □ M 2 <b>X</b> F	7. Age (In yrs. Ia 59	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Biri (Month, Da October	y, Year)	Cou	nplace (State or Foreign untry) ambodia
	10a. State 10b. County MD Montgo	mery		Town or Loc thersb	urg							10d. Inside City Limits 1X Yes 2 □ No
	10e. Street and Number 19108 Harkness L	ane			10f. Zip	879				10g. Citizen of What Country? United States		
De completed by I direial Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 ∐Yes If Yes, Gi Year or D	2 X No ive								14. Race - American Indian, Black, White, etc. ASIAN Specify:	
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00 an 01	17. Father's Name (First, Middle, Last) Pham Van Ngu	5+		Bus1	ness	Con		er's Nam	e (First, Middle, 11 Tua	Maiden S	Privat Surname)	<u>e</u>
	19a. Informant's Name/Relationship (Type. Print)  Henry Cohn – husband  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2  19108 Harkness Lane Gaithersburg MD 2087											
	20a. Method of Disposition  1									•		
	21. Signature of Funeral Service Licen	see	M01163	Ed	. Name ai ward	nd Addres	ss of Facili e I Fu Rock	nera vili	l Pirec	ŧion Rock	ville M	D 20852
	23a. Part 1. Enter 14 disease, or companies to the companies of the compan	a.		ian Ca			g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
CAGIIIIICI	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	b. Due to (or as a consequence of):									
5	resulting in death) Last	(or as a consequ	s a consequence of):									
completed by ruysician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 ②No 9 □ Unknown	1 ☐ Live	itcome of pregnar birth 2 ☐ Fetal gnant at time of de nown	death 3□	Ectopic   Other (s		у			2	23d. Date of del Month	ivery Day Year
a Dy LII	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   X No 3   Probably 4   Unknown											
and mos									24a. Was auto perfo 1 □Yes		prior to death?	topsy findings available completion of cause of
2	25. Was case referred to medical examiner?	Hospital: , _				. Oth	or.		th (Check only			
1011	1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?							ome 5 <b>X</b> Resi 28d. Describe	city)		
Medical certification, 10	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	e of Injury - At hor ling, etc. <i>(Specify</i>	me, farm, str	eet, factor				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Alcai C	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Examone)	niner: On the	e best of my know basis of examinat nner stated.	vledge, deatl ion and/or in	n occurred vestigation	d at the ti	me, date a opinion, de	nd place ath occu	e, and due to the rred at the time	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
2	29b. Signature and title of certifier				29	c. Licens	e number			29d. Dat	e signed (Mont	h, Day, Year)

To the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, C within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should

Physician /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Morbel Exercises must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

Victor M. Priego MD 6420 Rockledge Drive Suite 4100 Bethesda MD 20817 31. Date filed (Month, Day, Year)

OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 13 2009

D23308

October 12, 2009

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10, 2009 October 0 0410 Charles Erwin Carpenter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 44 Misty Meadow Drive Port Deposit Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1926 **Funeral** Hours Days Months 205-18-0350 83 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is in a factoring must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Cecil Port Deposit 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 44 Misty Meadow Drive 21904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. MXYes 2 □ No If Yes, Give Year or Dates: WW | | 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2√2√No Specify. Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pittsburgh Corning Corp. Elementary/Secondary (0-12) Eight Years College (1-4or 5+) Port Allegany, PA Utility Serviceman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles G. Carpenter Eva M. Rounsville ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife) 44 Misty Meadow Drive, Port Deposit, MD Donalyn O. Carpenter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition West Chester. F<u>ennsylvania</u> 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 10/11/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ancor **Physician** unprown disease or condition resulting in death) "/Medical Due to (or as a consequence of) Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00023322 10.10.2009 Jackour 8no Electon M02/921. HIVA 126 A, E tigh

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Denus B. parke

32. Registrar's Signature

Please Type or Print în Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10:02 a M 2. Date of Death Physician/ October 8 2009<sup>Year</sup> Jose Esteban Chavez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Salvador Director 281-49-1098 31 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3945 Newdale Rd. #35 20815 El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify: White If Yes, Give 3 Widowed 4 XDivorced Completed salvadoran Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "any Injury or other transmission." Elementary/Seconday (0-12) College (1-4 or 5+) Carpet Cleaner JCS Carpet Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jorge Chavez Vilma Esperanza Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3945 Newdale Rd. #35 Chevy Chase, Maryland 20815 Dyclas Cortez (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Derem 3 Removal from State 4 Donation 5 D Other Family Cemetery 10-18-09 El Salvador Signal e of Funeral Ser 22. Name and Address of Facility.H. Bacon Funeral Home, 3447 14th St. N.W. Washington DC 20010. 23a. Part I. Inter the disease, or complications that caused shock or heaft failure. List only one cause on each line. Immediate Cause (Final ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of, Exami that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. signed by 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 2 X No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natural within 24 hours a er decth.

To the Funeral Director A completed filled by the fi death. 1 🗀 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ortober 2009 Rosella Arlene Chase /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Hours Min. 1 □ M 2**X** F Yrs. Maryland 11/19/1934 Director 578-50-8868 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It. If collect Examiner must be mortified at once. 1√Yes 2 No Director Upper Marlboro Md. 10g. Citizen of What Country? 10e. Street and Number 20772 U.S.A. 3400 Hannon Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Bookhandler/GPO 11±h 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosella Doupe Richard I. Kidwell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Ann Chase/Daughter 3400 Hannon Ct., Upper Marlboro, Md. 20772 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/17/09 Washington, D.C. Glenwood Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
H.S.Washington & Sons Co., Inc. 21. Signature of Funeral Service License 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the discose, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed 100 burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I ☐Yes 2 No signed by the a Division of Vital Records, P.O. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an 2 After this certification and all the sections of the section. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Kakesh Arora

OCT 1 3 2009

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Se/14

- FoxLane, Suite 222

BOWIE, MD. 2071S

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	, , , , , , , , , , , , , , ,	Cer	tificate of D	Death	Reg	No 2009	34178
	Physicia		1. Decedent's Name (First, Middle, Last)  EVELYN	CARR				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	ities	4b. City, Town, or I	Location of Death	rle	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 18-24-7171	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, You September 2	ear) 9. Bir Co 29,1927 Mai	thplace (State or Foreign ountry) ryland
	ryland show	_	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc					10d. Inside City Limits
5-0036	he Ma 28a-f s	Director	Maryland Prince Ge	orge's R	iverdal	· · · · · · · · · · · · · · · · · · ·		10-	Citizen of Milest Co	1 ⊠Yes 2 □ No
	23a or 2	ral Dir	10e. Street and Number 4409 East West Hig	hway		10f. Zip Code	20737	109	, Citizen of What Co USA	ountry ?
	uid be hied within 72 hours after death with the Marylan Mental Hygiene.  Mental Hygiene.  Med other than "natural", or items 23a or 28a-f show tite event, It is made Exact in a nutst or malified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U. Armed Forces? 1		/as Decedent of His Yes, specify Cubar □Yes 2⊠No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
215-0036	iin 72 ho i. in "natur Nedical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give k	ent's Usual Occupa ind of work done du O NOT use retired)	uring most of workin		b. Kind of Business	/Industry
7.17	d wiff giene er tha	Com	Unav.	College (1-4or 5+)				Unav.		Unav.
Maryland 2	uid be file Aental Hy rked oth	To Be (	17. Father's Name (First, Middle, Last)  Howard Arthur Carr				18. Mother's Name Edith Rol	·		
ary	d 2 should to the and Men (the and Men (the standard) to the transfer transfer (the standard) to the standard	-	19a. Informant's Name/Relationship (Type	•	1				City or Town, State,	
	s 1 and 2 of Health item 27 other tra		Terry K. Sullivan						, Baltimo	re, MD 21202
altimore,	0 0 - <u>-</u>		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		atory or other place Cemetery	) ;		altimore,	
Rail	permit. Pag Department important: I any injury o		21. Signature of Funeral Service Licensee	e Dasel		Name and Address	ŕ			imore Avenue le, MD 20781
	N	12 1	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the deat cause on each line.	h. Do not ente	r the mode of dying	À	-	t,	Approximate Interval Between Onset and Death
	hysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	serge	Deme	ruce		
		iner	Sequentially list conditions, larger sequences and because in the Underlying Cause (Disease or injury	Due to for as a conseq	uence of):					
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09/89	errincate b ling physic e as the bu	Medical	d.						1	
	ueam or e attend ed for us	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown		23d. Date of delivery Month Day Year					
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Hec	ate has	Completed						24a. Was an autopsy performe	d?   death?	utopsy findings available completion of cause of s 2 □No
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no no	ing rnys  After this 'uneral di	ion: To	27. Manner of Death  1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	at 2	ne 5 ∐ Residend 8d. Describe how	ce 6 ☐ Other (Sperinjury occurred	ecify)
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	within To the compl	Me	29b. Signature and title of detrie		V.D.	29c. License			J. Date signed (Mon	
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R	, 1		30. Name and address of person who con	ren 440	n 23a) (Type, F ) 4	ut me	st Hwi	f Rue	rdale r	109.
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 3 2009	32. Register's Sign	all			-		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 – For State Registrar	State of Ma	aryland		artment of F		d Mental Hy	_	nna	31, 179	
	Physici	an	1. Decedent's Name (First, Middle, La		^ ~-	-			2. Date of Dea		Year	3. Time of Death	
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and the	Examin	er	Golden Age at Ava				Bowie	Location of De	au i		nce Ge		
	Funeral		5. Social Security Number 6. S		e (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 H	in. 8. Date of Birt	h	9. Birth	place (State or Foreign	
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	/land low		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
	a-fsh	ctor	MD Prince G	eorge's	Uppe	r Marl	.boro					1 ☐Yes 21 No	
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?	
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93	ral", o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	I∐Yes 21XINo	Specify:		S	pecify: WI	nite	
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ylar	should be filed within and Mental Hygiene. s marked other than umatic event, the M	TO E	Gilbert Michael H	ennen				Goldie Edith Dark			ey		
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.							1		
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	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only one)	ysiclan: To the best on niner: On the basis of and manner sta	f examinati	on and/or inv	estigation, in my o	pinion, death o	ccurred at the time,	date and pl	ace, and due	to the cause(s)	
	Vithir Comp	Me	29b. Signature and title of certifier	201			29c. License	e number		29d. Date s	signed (Month	Day, Year)	
		4	Trium J.C	2 enta	m		D	2143	8	Oct	ahr/2	, 2009	
A	-6		30. Name and address of person who	completed cause of d	eath (Item	23а) (Тур	Print)	HER.HU	Au ANN	APOLI	MAL	1401	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	r's Signatu	Jro	いてもいい	4 1 1 9 9	17/2/1000	,,,		1 7 1	
	Registra	-	OCT 1 9 2009	Zana A	As a	2							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ sept. ЗŎ, 2009 James Henry Coomes, Sr. 3:34 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, 1 🗓 M 2 🗆 F Months Min. Pennsylvania 216-28-0343 Hours 77 Director Nov. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director Anne Arundel Severna Park 28a-f 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1130 Old County Road 21146 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. was becedent even in c.s.
Armed Forces?
1 

Yes 2 □ No
If Yes, Give
Year or Dates. Korean Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed is marked other than "natur aumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Whiting-Turner Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oft,
any injury or other traumatic anona 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James George Coomes Elma Haines 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Henry Coomes, Jr./Son 1703 Aberdeen Court Crofton, MD 21114 Date 5, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rarranco & Sons, 495 Gov. Ritchie Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Ser autopsy perform death?
1 Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to endical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ER/Outpatient 3 DOA မ 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

AUN State

Medical

29a. Certifier

(Check

only one

30. Name and add

3

31. Date filed (Month, Day, Year) 0CT 06

ess of person who completed cause of death (Item 23a) (Type, Print)

2009

25

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00054903

134012 Solo:

29d. Date signed (Month, Day, Year)

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MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William McKinley Cosey, Jr. 1:15 A M 01, Oct. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 71 Dividing Creek Court Arnold 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 212-24-3657 81 Director Aug. 04,1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar and be nothed at Director Anne Arundel Arnold 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 71 Dividing Creek Court 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [X/es 2 □ No Korean If Yes, Give Conflict Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ William M. Cosey, Sr. Mabel L. Robison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan D. Cosey / Wife 71 Dividing Creek Court Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) oct.Date 02, 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 【X Cremation 3 ☐ Berneval from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2009 Baltimore, MD 21. Sımatur of Funeral Servi & Liçensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part I. Enter the disease, or complications that caused the death, shock, or heart failur. Lisy only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final I disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, page perform 2.2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Yes 2 | \$\dio \o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

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Name and address of person who completed cause of death (Item 23a) (Type,,Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a & Pt II per phys. 689, 11,6,09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 () () 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 25 200 Physician/ 21:56 M Helen Celeste Cole Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner WHY Memor 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Months Min. Hours 5/3/195 57 212-66-2291 DE **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traum tic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director 1 X Yes 2 No MD Talbot Easton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 601 Dutchman's Lane 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 
Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Secretary Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard Morton Cole Betty Lou Bayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2065 Roundtop Rd. Chestertown, MD 21620 Gregory Cole/ Brother 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Crumpton Cemetery 10/1/2009 Crumpton, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility. Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a/ bert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SHOCK disease or condition resulting in death) Medical Due to (or s a consequence of): **Examiner** Urosepsis Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by secondary to 1 Yes 24 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? hypertension and diabetes 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🙀 No 1 
☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms 31. Date filed (Month, Day, Year State

Registrar

23MIPE

		State Registrar	Ce	ertificate of D			No.200	9 3418
Physicia		1. Decedent's Name (First, Middle, Last)  Anna Isabel Caldwell				2. Date of Death Month	Day 17	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street, and VA Maryland Heart	h Care System	4b. City, Town, or L	Point	septemp	4c. County of	Death
Funeral Director		5. Social Security Number 216-16-1245  Usual Residence of Decedent	7. Age (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 3/14/192	ear) g	Birthplace (State or Forei Country) MD
ryland	_	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limit
the Maryland	ecto	MD Cecil	Perry P					1∭Yes 2□N
a or 3	ΙĎ	10e. Street and Number	1.1. 0.27	10f. Zip Code 21902		10g.	Citizen of Wha	it Country?
perfilt. Fages 1 and 2 should be filed within 72 hours after death with the Maryland beatment of Health and Model Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal mark by notified at once.	Completed by Funeral Director	1 X Never Married 2 Married 1 X Y	Decedent Ever in U.S. 13. 13. 15 Porces? 15 Porces 2 No Give	Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 🎇 No		ecify Yes or No- Rican, etc.)	14. Race - Black, V	American Indian, Vhite, etc. White
nin 72 nour 9. an "natural Medical Ex	pleted b	15. Decedent's Education (Specify only highest grade complete	or Dates:    16a. Dece   (Give   life,   edent's Usual Occupati e kind of work done du DO NOT use retired)	ion ring most of worki	ing 16t	o. Kind of Busin		
ygiene ygiene ier tha	Com	12 3	Nur	se			Health	Care
ed oth	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Mai	den Surname)	
Should nd Me mark mark	P L	Henry T. Caldwell  19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ng Address (Street an	Isabel H	-	ity or Town Sta	ate Zin Code)
alth a salth a 27 is er trau		Susan Kester/ POA	40	Amethyst				ne, 2ip 00de)
rages : c		20a. Method of Disposition  1  ☐ Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om State	osition (Name of matory or other place) Cemetery	9/29	.	Sey, M	y or Town, State
Departr Imports any infu		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications th		2. Name and Address ellows, He 70 W. Cypr	of Facility If enbein	& Newnam	Funera	1 Home
hysician in bulial-transit as the purial-transit as the purial-transit	ш	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	to (or as a consequence of):  to (or as a consequence of):					Unknow
	Physician/Medical	in the past 12 months?	outcome of pregnancy ve birth 2 ☐ Fetal death 3 [ regnant at time of death 5 [ nknown	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	f delivery Day Year
s been signed b	2	Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given	in Part I.		co use contribu	te to the cause of death?
cate has be	Completed					24a. Was an autopsy performed	? prior	e autopsy findings availabl r to completion of cause of h? Yes 2 No
certificate rector, pag	m į	25. Was case referred to medical examiner?  1	-	0.5		(Check only one)		
h. After this funeral di	n: To	27. Manner of Death 28a. D.	Inpatient 2 ER/Outpatier 28b. Time o	f 28c. Injury a		ne 5  Residence		Specify)
within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plant	fonth, Day, Year) Injury ace of Injury - At home, farm, str illding, etc. (Specify)		s 2 🗆 No	28f. Location <i>(Stree)</i> City or Town, Si	t and Number o	r Rural Route Number,
e Funeral	Medical Ce	Check only 2   Wedical Examiner: On th	the best of my knowledge, deat e basis of examination and/or in anner stated.	h occurred at the time, vestigation, in my opin	, date and place, a nion, death occurre	and due to the caus ed at the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
	Me	29b. Signature and title of certifier	inordez, l	29c. License n				Ionth, Day, Year) 23, 2009
10		30. Name and address of person who completed c	ause of death (Item 25a) (Type,	Print)	13/8	h Care	ept.	23, 2009 Perry Point, Mb

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9:35 am Carolyn Jean Davis October 03, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Nursing & Rehab Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 X F Yrs Director 466-84-0674 Texas 60 January 26, 1949 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. To 7 is marked other than "natural", or items 23a or 28a-f show her traumatic event, Ine Medical Examinar natural be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Funeral Director 1 ☐ Yes 2 X No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5309 Albermarle Street 20816 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 X No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 No \$ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtie Eugenie Sprinkle Daniel M. Chapman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health tem 27 i Anita Ford - POA 7150 Kings Arm Drive, Manassas, VA permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other other 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 10/13/2009 4 Donation 5 Dother (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cirrhosis of Liver /Medicai Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions Examiner Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Renal Failure and Due to (or as a consequence of) attending physician Physician/Medical Hepatitis C the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 5 ☐ Other (specify) signed by the a be detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Asthma 24a. Was an has autopsy performed 2 🗆 No 1 □Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗷 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) s after dec. 1 X Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital or within 24 hours at To the Funeral D 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only 29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month, Day, Year) D53691 October 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, LLC, 3200 Tower Oaks Blvd., Suite 110, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

OCT 13 2009

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene For State Registrar 34185 Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 6 Day 2009 Year **Physician** Anna L. Defrin 12:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/31/1920 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 1 □ F Months Days Hours Min MO 487-14-9096 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, It a Medical Examinar in ust be notified at 10b. County 10d. Inside City Limits Director 1 √2 Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with i nd Mental Hygiene. marked other than "natural" مو ناميد 13103 Valleywood Drive 20906 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White þ Specify. Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work dane during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental F Be Daynovsky Rose Korman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s Health ar Cloverbrooke Court Potomac MD 20854 Helaine Rooney - daughter item 27 20b. Place of Disposition (Name of King Day Orematory or other place)
Methorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If iter
any injury or ott 1 X Burial 2 ☐ Cremation 3X Removal from State 10/09/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of E J2. Name and Address of Tacilly Danzansky – Goldberg, Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiorgan Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Non-hodgkin Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): spiral or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 X No ı∏Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifie, 29c. License number 29d. Date signed (Month, Day, Year) D63343 October 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Ruban MD 1500 Forest Glen Road Silver Spring MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	tate of Marylan		artment of F tificate of D		ептаі нус ғ	Reg. No 2009	34186
	Physicia		1. Decedent's Name (First, Middle, Last)  Douglas Russe	ell Dyer				2. Date of Dea Month		3. Time of Death 22:00 M
	Medic Examin		4a. Facility Name (if not institution, give street	and number)		4b. City, Town, or	Location of Death	10	4c. County of Dea	
+	Francis		Washington Adventis  5. Social Security Number   6. Sex	7. Age (In yrs. la	ast hirthday)	Takoma F		8. Date of Birth	Montgomer	rthplace (State or Foreign
	Funeral Director		578-72-2460 1 1 1 1 M		Yrs.	Months Days		3-29-19	Year) Was	hington DC
	ryland I-f show ied at	ctor	10a. State 10b. County		y, Town or Loc					10d. Inside City Limits 1 √2 Yes 2 □ No
	he Ma or 28a e notif	Dire	DC 10e. Street and Number	Wash	nington	10f. Zip Code			10g. Citizen of What C	
	s 23a	Funeral Director	505 19th St NE			20002			nited Stat	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGE.	Completed by Fur	Never Married 2 Married	Vas Decedent Ever in U.S		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🙀 No	spanic Origin? (Spen n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:Bla	te, etc.
15-(	72 hor	mple	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give k	lent's Usual Occupa kind of work done of O NOT use retired)	ation luring most of workir	ng	16b. Kind of Business	Industry
212	l withir ygiene her tha t, the l	ပိ	10	ollege (1-4 or 5+)		1t Worke	r		Governme	nt
and	oe filec antal H ced otl	To Be	17. Father's Name (First, Middle, Last)  Douglas Russell Dyer	· Sr			18. Mother's Name		,	
ary	hould and Me s mar umati		19a. Informant's Name/Relationship (Type, Pri		19b. Mailin	g Address (Street a			; City or Town, State, Z	ip Code)
Σ	ind 2 s lealth a m 27 i		Valencia Brown / Fi			9th St N	E Washin	gton DC		
Baltimore,	. Page 1 a Iment of H tant: If ite jury or ott		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo	oval from State	emetery, crem	sition (Name of natory or other place can Crema	e) 10 1	3-09	20c. Location - City o Alexandria	
Balt	permit Depart Impor any in		21. Signature of uneral Service Licensee	W)	Po Po	. Name and Addres pe Funera	ss of Facility a1 Home 2	617 Pen	n Ave SE W	ashington DC 20020
	Physician/		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	se on each line.		r the mode of dying	g, such as cardiac o	respiratory arre	est,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ		484 946	ed Co	nist		
8	ed isit	miner	Sequentially list conditions, if any leading to in model cause. Enter Underlying Cause (Disease or linjury	Directo (or as a Honsage	senna cr):	/ /		30.1		
_	icate be executed physician and s the burial-transit	ledical Examiner	that initiated events c. — resulting in death) Last	Due to (or as a consequ	uence of):					
3760			d				-			
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To thin 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		in the past 12 months?	yes, outcome of pregnat Live Birth 2 Feta Pregnant at time of d Unknown	al death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
ds, P.O	quires that the signed bould be deta	þ	Part II. Other significant conditions contribu	ting to death but not res	ulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to	o the cause of death?  Probably 4 Unknown
Recor	: The law re cate has be page 2 sh	Completed						24a. Was a autop: perfor 1  Yes	sy prior to death?	utopsy findings available completion of cause of
/ital	rsician s certif director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospit	al:	ER/Outnation	_ Tothe	er:		ence 6 🗋 Other (Spe	o/fu)
Jo L	ling Phy n. After this uneral o		1 Natural 5 Pending	Ba. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at 2		ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 burns after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At ho building, etc. (Specify,			Yes 2 □ No	28f. Location (St City or Town	treet and Number or Ru n, State)	ural Route Number,
	he Hospit iin 24 hour he Funera pleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: 0 3 Certifying Nurse Pra	n the basis of examination	n and/or investi	igation, in my opinio	n, death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.
	Nith Not Com		29b. Signature and title of certifier	M D		29c. License	0601	02	29d. Date signed (Mont	th, Day, Year)
R			30. Name and address of person who comple	My BUD	5 =	ninti TH	Hmini	A IK	7.903	mrn
	Star Registra	.0	31. Date filed (Month, Day, Year)  OCT 1 3 2009	32. Registrar's Signat	backs	,				

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			For State Registrar	State of Man		partment of F Certificate of			giene Reg. No. 2009	34187
	Dhyoisi		1. Decedent's Name (First, Middle, Las	1				2. Date of Dea	ath Day Yea	3. Time of Death
	Physici /Media		Hngella B	Dickso	N			October	11 2000	4:10 HM
	Examir	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of De	
-21/-			Sanctuary at Holy			Burtons  (av) If Under 1 Year		0 D-1( Bi-	Montgome	
	Funeral Director		5. Social Security Number 6. So 578–48–4037	7. Age (1) 7. Age (1) 7. 79	In yrs. last birthd Yrs	Months Days	Hours Min.	8. Date of Birt (Month, Da June 29		kirthplace (State or Foreign DC
	land		10a. State 10b. County	11	0c. City, Town o	r Location				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	호	MD Prince G	eorges	Temple	Hills				1 □Yes 2⊠No
	r 28a	Director	10e. Street and Number	1 2 3 2 3		10f. Zip Code			10g. Citizen of What	Country?
	h with	at D	4308 Delmar Ave.			20748	3		USA	
	deat ems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H	Hispanic Origin? (Spe	cify Yes or No	- 14. Race - Ar Black, W	nerican Indian,
9	after or Ite		1 XNever Married 2 Married	1 □ Yes 2 XINo If Yes, Give		1 ☐ Yes 2 ☑ No		i iloan, oto.)	Specify:	
8	ours rral", LExa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Black
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121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Howard Un	iv. Hospital
2	illed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	4yrs	Keg	istered Nu		(First Middle	Maiden Surname)	IV. Hospitar
Maryland 21215-0036	d be	Be C	Alexander Dickso	n Cr				,	Braxton	
2	thoule mark matic	유	19a. Informant's Name/Relationship (7		19b. M	ailing Address (Street			er, City or Town, State	Zin Code)
Ma	nd 2 s Ilth ar 27 Is trau		Albert Dickson-Br		1.	8 Delmar A			lls, Md. 20	
	Hea Hea tem	37	20a. Method of Disposition			isposition (Name of crematory or other pla		ate nate	20c. Location - City	
D D	ages ent of it: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State		crematory or other pla Memorial	1	6-2009	Landover,	Mđ.
Baltimore,	nit. Fartmontar	1	21. Signature of Faneral Service Licen			22. Name and Address Marshall	1			
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	/Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence of):		ncer			
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o,	an ar		resulting in death) Last	Due to (or as a c	onsequence of):					
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99	rtifica ng ph as th	Med	IF FEMALE:					- 227		
Box	leath certific attending p for use as t	an/l	23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2 [		3 ☐Ectopic pregnanc	.v		23d. Date of o	
	e dea he at ied fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at tin 9□Unknown	ne of death	5 ☐ Other (specify) _			WOTH	Day Year
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ec	e law has b	ple						24a. Was	psv prior	autopsy findings available to completion of cause of
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Division or Vital Records,	s fer d at Direc	Certification:	4 Homicide determined	building, etc. (	- At nome, farm Specify)	, street, factory, office	;		Street and Number or wn, State)	Hural Houte Number,
	To the Hospital or Attend within 24 hours after death. To the Funeral Director A completely filled in by the fi	Medical (		ysician: To the best of r niner: On the basis of ex and manner state	camination and/c					
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	0		D. V. SHAR			D6	053337		October 1	2,2009
_	5		30. Name and address of he son who	completed of deal	th (Item 23a) (Ty	pe, Print)		300 S		
CH		ļ. V	Don'thy Seay	, MD 25	Main	Street S	unte zou	Kester	October 1 stown M	951136

State Registrar

te 31. Date filed (Month, Day, Year

Cenera B. Auris

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Helene Celeste Downs October 7, 2009 10:25A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3875 0ak Grove Place Charles Nanjemoy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2√2 F 577-36-8353 78 August 23,1931 Washington DC Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director Charles Nanjemoy 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 3875 Oak Grove Place 20662 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White \$ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Judge Orphans Court County Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Joseph Wilmer Johnson Helen Elizabeth Hayden permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is many injury or other traum: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Courtney Davis/Daughter P.O. Box 2 Nanjemoy, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Downs Family Cemetery 10/12/09 Nanjemoy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature funeral Service M01458 ZAREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RODUOM Physician MONTH disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner NUN Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and -trans physician ar Due to (or as a consequence of) Box 68760. Physician/Medical as t attending p for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>م</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? 1 ☐ Yes 2 🖸 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier WALDONF, MI ath (Item 23a) (Type, 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of	f Maryland		artment of ctificate of		and M	lental Hy	0	e 2009	34	189
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			HOLY CROSS HOSP				SILVER					ONTGOMER		
r	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bi (Month, D	ay, Year	) C	thplace (State ountry)	_
	Director		579-24-1121 Usual Residence of Decedent		83					8/30/	1926	Spa	rtansb	urg,SC
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36	urs aft	by F	3 ☐ Widowed 4 ☐ Divorced	ied 1 □Yes if Yes, Giv Year or Da	e ates:		1□Yes 2√√2No	Specify:				Specify: B1	ack	
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and	ld be fi ental F ked otl Ic ever	Be	17. Father's Name (First, Middle,	Last) Unknow	n			18. Mothe	ers Name	(First, Middle	e, Maidei	n Surname) [	Inknowr	ì
Š	s 1 and 2 should be if Health and Menta Item 27 is marked other traumatic ev	ဥ	19a. Informant's Name/Relations	nin (Type Print)		19h Mailir	ng Address (Stree	et and Numbi	er or Run	al Route Numi	her City	or Town State	Zin Code)	
<b>≥</b>	tra tra		Diane George /				Maxfield						.,	
ē,	Pages 1 and 2. ment of Health a ant: If Item 27 is lury or other trau		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Name of natory or other pl	ace)		Date		ocation - City or		
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Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any Injury o		21. Sign all e of Funeral Service	Licentes	,		. Name and Add				al I			Lytana
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9	eath certific attending p for use as	/Med	IF FEMALE:	23c If was out	come pf pregnan	OV.								
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	irth 2 ☐ Fetal o ant at time of dea	death 3□	Ectopic pregnan Other (specify)	су			1	23d. Date of de Month	livery Day	Year
o.	that the dened by the stacked is	Physician/Me	1	9□Unkno		0	curer (opcomy)							
ري. ص	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	by PI	Part II. Other significant condition	ns contributing to de	eath but not result	ing in the u	nderlying cause g	iven in Part I	,	23e. Did	tobacco	use contribute t	o the cause o	of death?
Records,	w requires to been signer should be a	ed b								10	Yes 2	2 □ No 3 □ P	robably 4	Unknown
900	law re as be 2 sho	Completed								24a. Was	s an opsy	24b. Were a	utopsy finding completion o	s available
Œ		E I								perf 1□ Yes	ormed?	death?	•	Cause of
Viital	cian: ertific	Be (	25. Was case referred to medical examiner?	I I %-I					of Death	(Check only	one)			
	Physician: r this certific ral director, i	은	1 ☐ Yes 2 🔼 No 27. Manner of Death	Hospital: 1 🔀 li 28a. Date d		R/Outpatien	LOUDON					6 ☐Other (Spe	ecify)	
Division or	ding I J. After funer	ion	1 ☑ Natural 5 ☐ Pending	g (Mont	h, Day Year)	28b. Time of Injury	W	uryat ork? ∃Yes 2⊟	i	28d. Describe	now inju	ary occurred		
<u>ISI</u>	or Attending after death. Director: After in by the fune	fical	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	of injury - At horr	ne, farm, str			-	28f. Location	(Street a	nd Number or R	ural Route N	umber.
<u>S</u>	afor / s after If Dire	Certification:	4 ☐ Homicide determi	buildir	ng, etc. (Specify)					City or To				,
	Hospital			g Physician: To the Examiner: On the ba										-4-)
		Medical	one)	and manr	ner stated.	711 allu/01 ill			atti occuii	ed at the time				
	To the within To the Comple	2	29b. Signature and title of certifier				29c. Licer	ise number			29d. Da	ate signed <i>(Mon</i>	th, Day, Year	)
Γ	10			_				67092			10/	7/2009		
2	10		30. Name and address of person					<b>:</b> 11.	Mare	land O	050	Contra	200	
	Sta	_	Ravi Passi, M.D. 31. Date filed (Month, Day, Year)	32 B	enistrar's Signatu	IFO	id_KOCKV	ттте,	mary	rand Z	uosu	Sulte	<u> </u>	
	Registr		OCT 1 3 2009	Denve )	B. Asa	Very								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PerMe, G897 11/2/09 11
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 34190 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 4 **Physician** VIOLET TURK ELLIOTT OCTOBER 2009 3:49a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Kent Chestertown 8. Date of Birth (Month, Day, Apr 5 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. New York 1 □ M 2 🛛 F 1924 113-16-1534 85 Apr Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location show traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director MD Kent Massey 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 12063 Galena Rd. 21650 U.S.A. 23a Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 ò White 1 ☐ Yes 2 No Specify Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Telephone Executive Telephone Company 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be William Turk Florence Fuller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health an Important: If Item 27 is any Injury or other trau (husband) 12063 Galena Rd. Massey, MD. 21650 Donald J. Elliott 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial 10/19/09 Sykesville, MD. 21. Signal III - Funeral Service Litense 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech
118 West Cros St. Galena, MD. 21635 M00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA **Physician** < 10 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DISEASE CARDIOVASCULAR HYPELTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEMPLEATION APPROVED BY MEDICAL ELIMINES. Due to (or as a consequence of) Examine be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical law requires that the death certificate the ası IF FEMALE: nse s yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ pe FRACTUR 21 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should peen s Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No has autopsy certificate 1 ☐Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 11/09 SubJect 1015 AM 1 ☐ Yes 2 V No 2 XAccident 10 filled in by the 6 ☐ Could not be 3 Suicide lace of njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Massey, M. Massey, MD 4 Homicide 32940 maryland Road 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one)

State Registrar

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Dr

within 2

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31. Date filed (Month, Day, Year) QCT 26

29b. Signature and title of certifie



le Min

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9, Physician Emanuel Friedman 2009 Bernard 2:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomeru | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Min. | Sept 18, 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Funeral Chico 1 **X** M 2 □ F 107-03-8361 93 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 shov injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6121 Montrose Road Funeral 20852 United States death 1 12. Was Decedent Ever in U.S.
Algred Forces?
1 ∰Yes 2 ☐ No 1941 —
If Yes, Give
Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Specify: 2 Specify: 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manufacturing and Elementary/Secondary (0-12) College (1-4or 5+) Distribution Business Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Friedman Joseph Bertha Landsman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. David Friedman. Potomac, 8804 Cold Spring Road. Maruland son Pages 1 gment of Hr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Demoval from State King David Mem. Gdn. 10/12/2009 Falls Church. Virginia 4 ☐ Donation 5 ☐ Other (Spenty) 21. Si nature of Funeral Service MUDZOG 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartifalure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? 1 ☐ Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mayiner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 ☐ Accident thin 24 hours area of the Funeral Director: Afternetely filled in by the fu 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b, Signature and title of certifier

State Registrar

OCT 13 2009

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

3. Registrar's Signature

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3altimore, Maryland 21215-0036

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Box 68760.

P.0.

Records,

Vital

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Division

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				of Maryland / Dep Ce	artment of Health and rtificate of Death	Mental Hygier	1e2009 3419	32
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Samuel Lewis Foggie,	Jr.		2. Date of Death Octhober 9	Pay 2009 <sup>Year</sup> 3. Time of Dea 1:52P	th M
	Examin		4a. Facility Name (if not institution, give street and n Southern Maryland Hospital Ce		4b. City, Town, or Location of Deat Clinton		4c. County of Death Prince George	
	Funeral Director		5. Social Security Number 6. Sex 1 🖾 M 2 🗆	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year		9. Birthplace (State or For Washington, DC	reign
	show dat		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Li	-
	e Mary r 28a-f notifie	Oirec	Maryland Prince George  10e. Street and Number	Upper Marl	boro 10f. Zip Code	1.0	1  Yes 2	No No
	n with th	Funeral Director	12414 Kayak Dr.		20772	10g.	Citizen of What Country? USA	
9600	filed within 72 hours after death with the Maryland al Hygiene. I other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at		11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Ya Pes, Fear or	es 2 No 1975 Give 1978	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 Ano Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Expone.	Completed by	15. Decedent's Education (Specify only highest grade complet  Elementary/Seconday (0-12)  College 5+	ed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) amployed Counselor	rking	. Kind of Business Industry	
yland	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Samuel L. Foggie, Sr.		18. Mother's Na Dorothy	me (First, Middle, Maide Moffett	en Surname)	
, Man	nd 2 shoul ealth and I n 27 is ma		19a. Informant's Name/Relationship (Type, Print) Erica F. Conrad/ Daughter		ng Address <i>(Street and Number or Ri</i> <b>reble Ct. Winston</b> Sa			
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth	2220	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Dispo cemetery, cre Kalas Cren	matory or other place)		Location - City or Town, State sewater, Maryland	
Balt	permit. Departi Import any inji	ļ	21. Signature of Funeral Service Licensee		2. Name and Address of Facility Geo .60 Oxon Hill Rd. Oxor			
	Physician/ Medical Examiner		23a. Part 1. Enter the discase, or complications the shock, or heart failure. List only only cause on Immediate Cause (Final disease or condition resulting in death)  a	at caused the death. Do not entered hine.	ny Syndrome		Approximate Interval Between Onset and Death (a. mor	us
092	icate be executed in physician and sthe burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c	to (or as a consequence of): to (or as a consequence of):	d Immuo dy	TONY	>10 y	ms
Box 68	ath certific attending for use as		in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
ls, P.O.	requires that the de been signed by the should be detached	ed by P	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death	
Division of Vital Records,	The law req ate has bee page 2 shoi	Complet	•			24a. Was an autopsy performed′ 1 □ Yes 2 □	24b. Were autopsy findings availar prior to completion of cause death?	able of
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		26. Place of Death (Che			
of V	ding Phys h. After this funeral di	te: To	27. Manner of Death 28a. Da	Inpatient 2 FR/Outpatiente of injury    Inpatient 2 FR/Outpatiente of injury   28b. Time of injury   28b. Time of injury   18b. Time		Home 5 Residence 28d. Describe how in		
vision	or Attendir fter death. irector: Af n by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm, sti ilding, etc. (Spec <i>ify</i> )	M 1 Yes 2 No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,	
Ō	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	Medical C	(Check 2 Medical Examiner: On the	basis of examination and/or inves	occured at the time, date and place, stigation, in my opinion, death occurred death occurred at the time, date and p	at the time, date and pla	ace, and due to the cause(s) and manner	stated.
		i> I		7. 15 the boot of my knowledge,	29c. License number		Date signed (Month, Day, Year)	
	To the within To the comp		29b. Signature and title of certifier					
•			· Mill	P3 Mauga Mause of death (Item 23a) (Type.	D4365		10.10.200	7
CR	Coti		30. Name and address of person who completed co	A Sugn - 41	D 4 3 6 5		10.10.200 Curron Mb	7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	1 = For State Registrar	, , , ,	Ce	ertificate of	Death		Reg. No	2009	34193
	Physicia	20	1. Decedent's Name (First, Middle, La	ast)		<u>.</u>		2. Date of De Month			3. Time of Death
	Physici: /Medic		Mary Anne Ferrel						.0,	2009	10:30 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Deat	h		County of Death	
	<b>-</b>		9319 Brandywine 1 5. Social Security Number 6. 8		last hirthda	Clinton	If Under 24 Hrs	. 8 Date of Bir	Pı	cince Ge	orges place (State or Foreign
	Funeral Director			1□ M 2♥ 69	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Oct. 18	y, Year) B, I	939 Vir	ginia ginia
	land ow		10a. State 10b. County		y, Town or l						10d. Inside City Limits
	e Mary 3a-f sh	Director	MD Prince (	Georges (	Clinto	on					1 □Yes 2XINo
	th with th 23a or 28 ust be no	ral Dire	10e. Street and Number 9319 Brandywine I	Road		10f. Zip Code 20735			_	S. A.	ntry?
980	be filed within 72 hours after death with the Maryland ntal Hygiene. In the matural", or items 23a or 28a-f show event, I'm Matural", or items 23a or 28a-f show event, I'm Matical Eval: if sections to a notified at	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1	S. 13	8. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🗓 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White, Specify: Bla	etc.
5-0	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occup	ation	rkina	16b. Ki	ind of Business/Ir	ndustry
121	filed within 'Hygiene. ther than "ent, In the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		re kind of work done of DO NOT use retired	d) most of wor	iking	Шол	spitalit	
d 2	filed I Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last	)	Wart	1699	18. Mother's Nar	me (First, Middle,			<u>Y</u>
ılan	hould be and Mental marked o	To B	Robertson Ferrell	1			August	a Clark			
lary	2 should and Men is marke	Ē.	19a. Informant's Name/Relationship (	(Type. Print)	19b. Mai	iling Address (Street	and Number or Re	ural Route Numb	er, City o	or Town, State, Zi	p Code)
, Z	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Cynthia Bethea -			Brandywi	ne Road,				
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If Ite any injury or otl		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)	Removal from State	emetery, ch	position <i>(Name of</i> ematory or other place IIIIs Ceme		Date 17-2009		ocation - City or To ville, V	
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	Jusen		22. Name and Addre	B				Home, P. A.
			23a. Pr t.l. Enter the disease, or com sinck, or heart failure. List only	r ic tions that caused the death	h. Do not e	503 Old Bran nter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	20/48	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	21					
		ē	Sequentially list or different in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	uence of):	arny					-11-
	cuted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
30,	certificate be executed ding physician and se as the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequent	uence of):						_
68760,	physicate by the p	Medical		d							
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of deliv	very
O.	requires that the death c been signed by the attend hould be detached for us	Physician/	in the past 12 months? 1 □Yes 2 ★No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		☐ Ectopic pregnanc ☐ Other (specify) _	у			Month	Day Year
S, P.	iw requires that s been signed by should be deta	by Ph	Part II. Other significant conditions of	contributing to death but not rest	ulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco ı	use contribute to t	the cause of death?
ord	require een si ould b	ted						1 🗆 \	res 2	□ No 3□ Pro	bably 4 Unknown
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Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Lon		ath (Check only o	ne)		
of	Phys r this ral dir	<u>۔۔</u>	1 ☐ Yes 2 No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpation 28b. Time		4 L Nursing F	lome 5 Resid		6 ☐ Other (Speci	fy)
ion	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Worl	yan k? Yes 2∐No	Zou. Describe i	iow irijui	y occurred	
Divis	after death. I Director: After	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At he building, etc. (Specif	ome, farm, s	treet, factory, office		28f. Location (S City or Tou		d Number or Run )	al Route Number,
	Hospi 4 hou Funer tely fil	Medical C	29a. Certifier (Check only one)  1 Certifying Pt 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or	ath occurred at the tin investigation, in my o	me, date and place ppinion, death occu	e, and due to the urred at the time,	cause(s date and	) and manner as I place, and due t	stated. o the cause(s)
	To the within 2 To the comple		29b. Signature and title of certifier	Mb		29c. Licens	085		10	telsigned (Manth,	440
		-	30. Name and address of person who	completed cause of death (Item	23aV(Tvpe	P, Print)	7 11	2 0 1	10	1010	009
2	8		30. Name and address of person the VENKAT - S - CA	mtman +501	50,	RCATIS K	+ A9 #	507 0	UN	ton Ml	20735
	Stat Registra	е	31. Date filed (Month, Day, Year) 1 3 2009	32. Registrar's Signa	Me						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11:40 PM Sharon Louise Finn 2009 Oct. 02, 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Anne Arundel 954 Hilltop Road Arnold 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 61 Months Days Hours Min 217-50-8338 Dec. 30,1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Anne Arundel Arnold 1 ☐ Yes 2 X No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21012 USA 954 Hilltop Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County College (1-4or 5+) Elementary/Secondary (0-12) Development Officer Public Schools 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Wolf Mildred Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 954 Hilltop Road Arnold, MD 21012 Michael J. finn, Jr./ Husband Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 07, Meadowridge Memorial Elkridge, MD 4 Donation 5 Dother (Specify) Park 2009 21. Signifiure of Funeral Service Licens 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 22 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DNG Cancer one year disease or condition resulting in leath) Due to (or as a consequence of): Secrentially list conditions if ny, leading to immediate ause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Ather (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed attending physician and for use as the burial-tra P.O. Box 68760, signed by the a Division of Vital Records, s been si cate has bage 2 s this certificate

Exar Physician/Medical Completed by Be P Certification:

27. Manper of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

29b. Signature and tifle of certifie

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

th and Mental Hygiene.
7 Is marked other than "natural", traumatic event, the Medical Exp.

of Health of item 27 is

permit. Pages Department of Important: If it any injury or o

**Physician** 

/Medical

Examiner

item 27 other t

Baltimore, Maryland 21215-0036

/Medical

MD

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

State

31. Date filed (Mont 0°6

5 ☐ Pending investigation

6 ☐ Could not be

Selonicu.

28a. Date of Injury (Month, Day, Year)

and manner stated

28c. Injury at Work?

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Annapolis,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Bestgate Stravt MO 900

Registrar's Signature park

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 11, 2004 at GINSBURG **Physician** NORMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERS OLNE MONTGOMERY GOVERTY HOSPTAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔼 F September 25,1934 District of Columbia Director 577-42-8201 75 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 10a State show ral", or items 23a or 28a-f shov Examiner nest be nutified at 1 □Yes 2 TNNo Director Montgomery Rockville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 U.S.A. 4418 Faroe Place Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 ∐Yes 2 KINo if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify Specify White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin Reid Estelle Stoutsenberger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other training once. 4418 Faroe Place, Rockville, Maryland 20853 Lawrence J. Ginsburg - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/16/2009 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Lidensee Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 M01241 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final RESPIRATION FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) CHRONIC OBSTRUCTIVE PULMONATED DISMAGE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of) 68760, Be Completed by Physician/Medical Box IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No o. To the Hospital or Attending Physician: The law requires that the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ADVINCED SMALL CHIL WING CHILCOR; AVLMONITO 1 Yes 2 No 3 Probably 4 Unknown EMBOLYS: MRITH FIBRILLHOW 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA Certification: To 1☐ Yes 2☑ No 1 npatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicei Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 136252 OCTUBER 11,2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST #500 KWSNGTON MD 2089 T 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Ivia		Certificate of			Reg. No. $200$	9 3419
	Physici	an	1. Decedent's Name (First, Middle, La Jeanette	st) M •		Goor		2. Date of Dea Month	er I2, 200	3. Time of Death 215 A M
and the	/Medic		4a. Facility Name (If not institution, giv				Location of Death		4c. County of De	
	LXaiiii		Rockville Nursing			Rockvi			Montgom	ery
	Funeral Director		5. Social Security Number 6. S 578-50-7721  Usual Residence of Decedent	ex	(In yrs. last b	irthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat July 3	9. B 1, 1914 N	irthplace (State or Foreign Country) ew York
_	yland now		10a. State 10b. County			vn or Location				10d. Inside City Limits
14	e Mar Ba-f sl	ctor	MD Montgo	omery	Beth	esda				1 ☐ Yes 2 ☐ No
PH-	tth with th 23a or 21 ust bund	<b>Funeral Director</b>	9301 Cedarcrest D	rive		10f. Zip Code	814		10g. Citizen of What C	•
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Modical Examiner rust be recitied at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2\(\frac{1}{2}\) No		pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. White
15-(	"natu	lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16	<ul> <li>Decedent's Usual Occup (Give kind of work done life. DO NOT use retired</li> </ul>	ation during most of work	ring	16b. Kind of Busines	s/Industry
212	l withir giene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	)	Statisticia			Federal G	overnment
pu!	be filed tal Hyg d othe event,	Be Completed	17. Father's Name (First, Middle, Last,	)				, ,	Maiden Surname)	
ryla	d Men marke matic	၉	Isaac Mindel	Toron Defeat	1.40		Esther			
e, Ma	and 2 st tealth an tm 27 is r ther traur		19a. Informant's Name/Relationship ( Ron Goor - Son	Type. Print)	. !	b. Mailing Address (Street 9301 Cedarcr	est Drive	Bethes	da MD 2081	4
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, Its Mudical once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 ■  4 □ Donation 5 □ Other (Specif	y)	King M	of Disposition (Name of Day) crematory or other place of Card Card	ens 10/1			ch, VA
Bal	permir Depar Impor any Ir		21. Signature of Funeral Service Licer	MO11	63	22. Name and Addre Edward Sa 1091	ss of Facility gel Funer Rockville	al Dire Pike R	c <b>tion</b> Inc ockville M	D 20852
8			2 a. Part 1. Ther the disease, or commonly limited to Cause (Final	plications that caused t one cause on each line	he death. Do	not enter the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hyper Due to (or as a		Heart Dise	าระ			
	Examiner		Sequentially list conditions			ic Stenosis				
	sit ed	niner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as g		ementia				
D.	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a						
68760,	tificate be executed ig physician and as the burial-transit			d						
e 68	ertifica ling ph e as th	Medi	IF FEMALE:							
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.  To the Funeral Director. Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal deat	h 3	у		23d. Date of d Month	elivery Day Year
S,	ss that gned b e deta	y Pr	Part II. Other significant conditions of	ontributing to death but	not resulting	in the underlying cause giv	en in Part I.			to the cause of death?
ord	equire een siç ould b	ted k						1 🗆 Y	'es 2 □ No 3 □	Probably 4 🔀 Unknown
Division of Vital Records,	The law I	Completed						24a. Was autop perfor 1 □ Yes	rmed? death	autopsy findings available of completion of cause of ?
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		utrationt 3 🗆 DOA Oth	26. Place of Deat	`		
of	g Physer this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatien  28a. Date of Injury (Month, Day,		Time of 28c. Injur	vat		lence 6 Other (Sp now injury occurred	pecify)
ion	ending sath. or: Afti he fun	atio	1 ☑ Natural 5 ☐ Pending investigation	1	Year)	Injury Worl  M 1	<br Yes 2 □ No			
	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	arm, street, factory, office		28f. Location (S City or Tow	Street and Number or i in, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 1 Certifying Properties (Check only one)	ysician: To the best of nIner: On the basis of a and manner state	examination a	ge, death occurred at the ti nd/or investigation, in my c	ne, date and place pinion, death occur	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	-	Me	29b. Signature and title of certifier	V. Sos	unh	29c. Licens D473			29d. Date signed (Mor	
	10		30 Name and address of person who Thomas V. Joseph			(Type, Print) Ston Drive St	uite 207	Rockvil	le MD 2085	2
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar	's Signature	1.41				
	Registr	ar	OCT 13 200	9 Denna	A. 1	parked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Phyllis Kennedy Galt 10,2009 tober 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign
Country) Social Security Number 7. Age (In yrs. last birthday Hours Days 1 ☐ M 2 🖾 F Months 201-16-4510 85 August 9, 1924 Harrisburg, PA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 No Virginia| Campbell Rustburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24588 2443 Clarks Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cassius M. Kennedy Josephine Steese 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry G. Mathers / Daughter 5626 Ruatan Street, Berwyn Heights, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 10/17/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COMMUNITU Due to (or as a consequence o): 23d. Date of delivery Month Day Year tobacco use contribute to the cause of death?

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, it a Madical Examinar in ust be notified at

death with the Maryland

1 and 2 should be filed within 72 hours after

and Mental Hygi is marked other

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau

traumatic

Baltimore, Maryland 21215-00

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sician and burial-trans the attending physician after death

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Exa
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Physiciar
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ion: To Be (

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ical

Sequentially list or differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.	orns/ 1	>150HAE
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
Part II. Other significant conditions  H PRUADE	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death  2 No 3 Probably 4 Unkr  24b. Were autopsy findings availing rior to completion of cause death?
		1 □ Yes 2	
25. Was case referred to medical examiner?	26. Place of Death		
1 Yes 2 No	Hospital:   Other: 4   Nursing Hon	ne 5 🗌 Residence	6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at Work?   28c. Injury at Work at	28d. Describe how inj	
3 ☐ Suicide 6 ☐ Could not 6 ☐		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier (Check only one)	Physician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)

within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and D35559 OCTOBUR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1252 State Registrar

24 hours a

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:30 A M 2009 Sherry Lynn Godhard October 0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel 1008 Branch View Ct. Harwood Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Hours 1 □ M 2XXF Months Days **Director** <u>Virginia</u> 212-54-2764 61 May 8. 1948 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedford Examination Examination once. 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No No Director Maryland Anne Arundel Harwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1008 Branch View Ct. 20776 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X** No Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rural Mail Carrier U.S. Post Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Richard McConaughy Joy Jordan ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Patrick Godhard/ Husband 1008 Branch View Ct., Harwood, MD 20776 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify)
21. Signature of your a Service Licensee Kalas Crematory 10-6-09 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 5 WWW disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☑ No Month Ye ar Pregnant at time of death 5 Other (specify) ed by the detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an After this certificate 1 □ Yes 2 □ MG 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated nd title of ce License number 29d. Date signed (Month, Day, Year) 29b. Signature of death (Item 23a) (Type, Print) Name and address of pe

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** MARY CATHERINE GOMER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** NMHS-P Allegon moer Kind If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🗓 F MARYLAND 1946 62 Director 214-46-3639 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1 ☐ Yes 2X No ir than "natural", or items 23a or 28a-f si Director MD ALLEGANY FROSTBURG 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 21532 109 AVENUE A U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mangue Jonee. Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN HAIR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STANLEY HITCHINS ANNA FATKIN HITCHINS ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 349 LAUREL WOOD DRIVE C -3 LONACONING MD 21539 STEPHANTE BEEMAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State VALE SUMMIT CEM. 10-22-2009 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. Sowers moasyo 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Tan ongestive disease or condition resulting in death) YN /Medical Due to ( s a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examine or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No s been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 \Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course. 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifie

SUNIT

Year)

31. Date filed (Month, Day,

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within 2

JUENUE

and manner stated

35

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

130033280

Cumbercaus

29d. Date signed (Month. Dav. Year)

			For State RegistrarAMFND	#10h		•	and / Depa	artmen rtificate				ental Hy	giene Reg. No.	20	09	3420
	hysicia	an	Decedent's Name (Fig. 1)			<i>у</i> <u>н</u>						2. Date of De	eath Day	,	Year	3. Time of Death
	/Medic	al	Phy11is  4a. Facility Name (If not	Ant		mber)	Halter		Town or	Location of		Octobe		County of		2:20 A.M
d .	Examin	er	15210 Spr:	_		irriber)		Darn			or Beati			ntgo		
	uneral rector		5. Social Security Numb	per 6. Se		7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, D) 06/17/	rth ay, Year) 1943	1	Coun	lace (State or Foreign try) ington, D(
and	A L		Usual Residence of Dec 10a. State 10	cedent b. County		10c.	City, Town or Lo	ocation							1	0d. Inside City Limits
Maryl	a-f sho	tor	MD I	Montgome	ery	Da	arnestow	'n								1 □Yes 2 No
ith the	or 28a e noti	Direc	10e. Street and Numbe					10f. Zip							hat Coun	
eath w	s 23a nust b	Funeral Director	15210 Sprin	ngfield		edent Ever in	alis 13	208		snanic Or	rigin? (Sne	cify Yes or N			State	es an Indian,
O Z IZ IS-UUSO filed within 72 hours after death with the Maryland Hygiene.	Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4 ☐</li></ul>		Armed F	orces? 2 <b>⊠</b> No ive	1	If Yes, spec		n, Mexical		cify Yes or Ne Rican, etc.)			k, White,	
72 ho	'natur dical E	eted	15 (Specify o	. Decedent's Ed only highest gra	ucation de completed)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation Juring mos	st of workir	ng	16b. Ki	ind of Bus	siness/Ind	dustry
Mar yland AIAI: 12 should be filed within 7 h and Mental Hygiene.	than he Me	Completed	Elementary/Seconda	ry (0-12)	College	(1-4or 5+)		1 Age		,			In	rave: dust	l ry	
e filed	other vent, t	Be Co	17. Father's Name (Firs	st, Middle, Last)						18. Moth	er's Name	(First, Middle				
ylal ould b Menta	arked atic e	To	Simon Clar									enberg				
Mar d 2 sh th and	7 Is m traum		19a. Informant's Name Robert L.	. ,		ichand	195.441 15.21 -1.5.21	ng Address Spri	ingij	ield <del>own</del> l	Rd; Ruri	Darnes Darnes	town ,	r <sup>T</sup> Mb :	<sup>S</sup> 2687	4 <sup>ode)</sup>
stan fHeal	Item 2 other		20a. Method of Disposit	tion		20	b. Place of Disponentery, cre	osition (Nar	ne of	1		ate				own, State
Page nent o	ant; If ury or		1 🖾 Burial 2 □ C 4 □ Donation 5 [			State No	orbeckMe	moria	.1 Pa	rk			ı	ey,		
partirior permit. Pages Department of	Imports any Inj once.		21. igna or of Fu	Service Licen	see	10120	55 I	2. Name ar .nc .	nd Addres 1091 Rock	s of Facili Rocl	w Edw kvill e, MD	ard Sa e Pike 20852	gel	Fune	ral 1	Direction,
			23a. Part1. Enter the c shock, or heart fa	ailure. List only	one cause on	each line.		ter the mod	le of dyin	g, such as	s cardiac c	or respiratory	arrest,			Approximate Interval Between Onset and Death
100	sician edical		Immediate Cause (Final disease or condition resulting in death)	al	d	g Cano	sequence of):									2.5 Years
	miner				Due to	(or as a con	sequence or):									
70	#	iner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause Unsease or inju-	ions, ediate ng	Due to	(or as a con	sequence of):									
xecute	and I-trans	Examine	that initiated events resulting in death) Last	_	c	(or as a con	sequence of):									
ate be ex	ohysician and the burial-transit	dical E			.d											
rtificat	ng phys as the		IF FEMALE:												1	
ecords, P.O. BOX 66/00, law requires that the death certificate be executed	been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 N 9 ☐ Unknown	nths?		birth 2 ☐ I nant at time	Fetal death 3	⊒Ectopic pi ⊒ Other (sp						23d. Date Mor	e of delive	ery Day Year
that t	ned by e detac	by Ph	Part II. Other significa	nt conditions	ontributing to	death but not	resulting in the	underlying c	ause give	en in Part	I.	23e. Did	tobacco	use contr	ribute to t	he cause of death?
ecords,	en sign											1 🗆	Yes 2	No No	3 ☐ Prob	oably 4 □Unknow
<b>L</b> e	ate has page 2	Completed										per	s an opsy formed? 2 <b>X</b> No	, c	Were auto prior to co death? I □ Yes	opsy findings availabl mpletion of cause of 2□ No
Or VICAL FOR	certifica rector,	Be	25. Was case referred examiner?	1	Hospital:				Othe	05:		(Check only				
	. <u>©</u> : <u>©</u>	1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date	e of Injury	2 ER/Outpatie		28c. Injun Work	4 🗆 14		me 51 Res 28d. Describe				fy)
VISION Attending	tor; After the	ation	2 Accident	5 ☐ Pending investigation		nth, Day Yea	Ir) Injury	М		Yes 2	] No					
or Atte	iera! Directo filled in by ti	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could not be determined	200. Flat	ce of injury - / ding, etc. (Sp	At home, farm, st necify)	reet, factor	y, office			28f. Location City or To	(Street ai own, Stati	nd Numb e)	er or Rur	al Route Number,
DIVISIO the Hospital or Attendi thin 24 hours after death.	To the Funeral completely filled	Medical Ce			niner: On the		knowledge, dea nination and/or i									
To the within	To the	Me	29b. Signature and title	e of certifier			1		c. License	e number				-	d <i>(Month,</i>	Day, Year) 2009
1/2			30. Name and address	s of person wh	Lomplet A car	use of de %b	(Item 23a) (T pe	, Print)								
			Cheryl Ay	/leswort	h, MD	2730	Univers		lvd,	#70C	) Wh	eaton,	MD 2	20902	2	
	Sta Regista		31. Date filed (Month, OCT 1	Day, Year) 13 2009	Denes	Registrar's S	ignature	20								

		-	State of Maryland  1 - State Registrar	d / Department of H Certificate of I			ene g. No. 2009	31,203
	Physicia	an	1. Decedent's Name (First, Middle, Last) Ronald Hendler			2. Date of Death Month October	<b>2009</b>	3. Time of Death 9:30 A.M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 12824 Clarksburg Square Road #3		Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. Ia. 42		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 1	9. Birth Cou 0,1967 Ne	pplace (State or Foreign intry) w York
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examinating the notified at once.	eral Director	MD Montgomery  10e. Street and Number  12824 Clarksburg Square Road #		371		g. Citizen of What Cou United St	ates
9036	ours after de <b>ural", or item</b> Lexaminae u	d by Funeral	11. Marital Status  1 X Never Married 2  Married 3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1	If Yes, specify Cuba 1 ∐Yes 2 🛣 No	Specify:		Black, White	hite
21215-0036	I within 72 h jiene. <b>r than "natu</b> ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Small Business	during most of work d)		6b. Kind of Business/I	
and	ild be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)  Jack Hendler		18. Mother's Name	e (First, Middle, Ma ne Refsor		
, Maryland	tnd 2 shou saith and M		19a. Informant's Name/Relationship (Type. Print) Tanya Hendler/ Sister	19b. Mailing Address (Street 12824 Clarksbu		e Road #3	302, Clarks	sburg, MD
Baltimore,	Pages 1 ament of He tant: If item		1  Burial 2 □ Cremation 3 □ Removal from State Par	ace of Disposition ( <i>Name of</i> emetery, crematory or other pla klawn Memorial k Cemetery	Octo	ber 13	ockville,	
Balt	permit Depart Import any in		21. Signature of Funeral Service Signature  RACYA STUDE MOIIT  23a. Part 1. Enter the disease, or complications that caused the death.	DeVol Fun	eral Home aithersbu	, 10 Eas	t Deer Par 0877	k Drive,
8760, 9	Physician / Medical Examiner the private and the private of the pr	dical Examiner	shock, or heart failure. List only one cause on each line.	inac arrythmence of):  yothic Mus				Interval Between Onset and Death Onset and Death Onset and Total
P.O. Box 6	death certifi e attending d for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of december 1 ☐ Unknown	death 3 Ectopic pregnand	су		23d. Date of del Month	ivery Day Year
	v requires that the description is been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not result	Ilting in the underlying cause given	ven in Part I.	23e. Did tob	acco use contribute to s 2 No 3 □ Pi	o the cause of death?
II Recol	The lay ate has page 2	Completed	weight loss			24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of 2  □No
Division of Vital Records,	Attending Physician: The r death. ector: After this certificate by the funeral director, pag	Certification: To Be	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 6 Could not be	28b. Time of Injury M 1 E	ner: 4 🗆 Nursing H	28d. Describe ho	nce 6  ☐ Other (Spe w injury occurred	
Divi	2 # # c	Certifi	4 ☐ Homicide determined building, etc. (Specify			City or Town		
	To the Hospital of within 24 hours at To the Funeral Completely filled in	ledical	29a. Certifier (Check only one) (Check o	tion and/or investigation, in my	opinion, death occu	rred at the time, da	ate and place, and due	e to the cause(s)
	S with	Σ	29b. Signature and title of certifier	29c. Licen	53129		9d. Date signed (Mont	109
_			30. Name and address of person who completed cause of death (Item Dale Heitzig Mi)	610 501	wex c	t frea	derick	MD 21703
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 13 2009  32 Registrar's Signat	1. bares				

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				epartment of Health and N Certificate of Death	Mental Hygier	ne.2009 34204
F			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medi		Muriel J. Hess		October	11 2009 04:45 AM
	Examir	ier	4a. Facility Name (If not institution, give street and number)  29 Bluff Drive	4b. City, Town, or Location of Death Conowingo		4c. County of Death  Cecil
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 ☐ M 2€3€ 73 Y	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 6, 1	9. Birthplace (State or Foreign Country) Maryland
Ī	show	'n	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ∐Yes 2√√No
	the N 28a-f	Director	Maryland Cecil Port	Deposit 10f. Zip Code	100	Citizen of What Country?
	3a or		110 Nantucket Drive	21904	"	ited States
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within 72 houn Hygiene. other than "natural ent, the Medical Exert	Completed b	15. Decedent's Education 16a. I	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	king 16b	. Kind of Business/Industry
7	filed withir Hygiene. other than ent, the M	Con	12	Salesperson		Retail
/land	2 should be fill and Mental H is marked oth raumatic even	To Be	17. Father's Name (First, Middle, Last) Milton E. Johnson		e (First, Middle, Maid Elizabeth	,
	1 and 2 sho Health and I em 27 is ma other trauma	ľ		Mailing Address (Street and Number or Ru. Bluff Drive, Conow:		
altimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Bemoval from State cemetery	ry Anne's Octol	ber	Location - City or Town, State
Balt	permit. Pages Department of Important: If ii any Injury or once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility C:	rouch Fune	rth East, Maryland ral Home East, Maryland21901
8/60,	Physician / Medical Examiner bulk sician and street prize the prize transit street prize the prize transit street prize the prize transit street prize trans	dical Examiner	Immediate C se (Final disease or co dition resulting in de ith)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of c. Due to (or as a consequence of d.	):		Onset and Death ilnknown
O. Box o	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 No 9 ☐ Unknown  1 ☐ Ves 2 No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
II Kecoras,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
r Vital	Physician: r this certific ral director,	To Be (	25. Was case referred to medical examiner?  1  Yes	Othor	th (Check only one)	e 6 □Other (Specify)
DIVISION OF	ffel ne	Certification:	27. Manner of Death    Natural   5	ury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street City or Town, St	and Number or Rural Route Number,
ב	re Hospital or Attendir n 24 hours after death. re Funeral Director: Al bletely filled in by the fu	edical Cer	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, edical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hosi within 24 ho To the Func completely f	Me	29b. Signature and title of certifier	29c. License number	449 29d.	Date signed (Month, Day, Year)
	10		3 plame and address of person who completed cause of death (Item 23a) (Toloria Dimonson WD) ///		wite 30	2 ETK/m MD2192
	Sta Registi		31. Date filed (Month, Day, Year)  OFT 13 2009  32. Registrar's Signature	Sall		

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:09 A M June Marie Horn 30 2009 /Medical <u>September</u> 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 521-14-4053 53 **Director** 8/9/1956 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be rodffled ≇t 1 Yes 2 No Director Prince Georges Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4113 56th Ave. 20710 US Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Aide Daycare permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Melvin Emmett Pohlmann Mary Ellen Burleson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Horn / Husband 4113 56th Ave. Bladensburg, MD 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln 10/8/2009 Brentwood, MD 21. Signature Funeral Servi 22. Name and Address of Facility Fort Lincoln Funeral Home rances 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Coronary Artery Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 🔀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔂 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗆 No 1 □Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 反 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and lifle of 29d. Date signed (Month, Day, Year) 29c. License number 10/2/2009 on who completed cause of death (Item 23a) (Type, Print) Dr. Delbert Morales 115 Centerway Greenbelt, MD 20770 31. Date filed (Month, 82. Registrar's Signature State OCT 1 3 2009

DHMH 17 Rev 1/2001

Registrar

Contract Name   First Market   Contract Name			For State Registrar	State o	f Marylan	d / Depa <i>Cer</i>	artment of I tificate of I	Health a Death	and M	ental Hyوا ا	giene Reg. No. 2 (	09	3420	16
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Secretary   Control   Processor   Control			214-34-7076		0 . ,		Months Days	Hours	Min.	(Month, Day <b>January</b>	25, 1919	Cot	untry)	•
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The position of Medical Examiner   Medical Examin			23a. Part 1. Enter the disease, or co	omplications that c	aused the death							<u> </u>	Approximate	) 1
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Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or Injury that Inflated events resulting in death) Last.    Due to (or as a consequence of):	/						Cuici	1000	-3 00	10000	Not Clar			
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FEMALE   23d. Date of delivery   23d. Date of delive	ed 1sit	min.	cause. Enter Underlying											
FEMALE   23c. If yes, outcome of pregnancy   1   Live Birth   2   Fetal death   3   Ectopic pregnancy   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Fetal death   3   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   1   Live Birth   2   Described for the cause of death   2   Described for the cause of death   2   Described for the cau	execut n and al-tran	Exa	that initiated events c											
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10 Syan - C. Jurano. D 50653 10-12-2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. JURANA  5851- Reale Church Lon Road Deale mb 20757	eath. or: Aff	fica	2 Accident Investiga	tion	n, Day, Teal/	III July			No					
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DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34207 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2110 PM 2000 oseph Kobert Howlin retober /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Social Security Number 6 Sax 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 10/26/1943 9. Birthplace (State or Foreign **Funeral** Hours 1√2 M 2□ F Months Days Washington,D.C. 216-40-6412 65 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ther traumatic event, the Medical Exeminer must be notified at 1 ☐Yes 2√☐ No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3570 Loch Haven Drive 21037 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Warehouse Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Robert Howlin, Sr. Rita Marie Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Rae Howlin/Wife 3570 Loch Haven Drive, Edgewater, MD 21037 Department of Health Important; If item 27 any injury or other the once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Kalas Crematory 10/10/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a conse uence of): disease or condition resulting in death) /Medical Examiner multiple fractures Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ET ST WEDGA EXAMINE motorcycle burial-tran Due to (or as a consequence o) physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ icate has been significate has been significated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1235 PM 1 ☐ Yes 2 ☑ No 2 Accident 9/16/09 28f. Location (5 of 1 and Number or Rural Route Number, City or Town, State) filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely

State

Registrar

Medical

29a. Certifier

(Check only one)

After this

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Bay Bridge Easthound Bay Bridge Easthound Bay Bridge Gentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

anen mo

Baltimore

MD 2120

October

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Gree 1e

Italonen 22 South

Registra s Signature 2009 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Z-, 2009 **Physician** James Arnold Hines Ober /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 22,1958 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Min. 1 M 2 □ F 51 Months Days 219-68-2541 Director Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Arnold Director MD Anne Arundel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 885 Willys Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: à permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Example. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility Company Cable Splicer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Douglas Hines Bertha Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Jane Hines / Wife 885 Willys Drive Arnold, MD 21012 Oct. 0. 2009 Date 5 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, INC. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Pert 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line elogen ous Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 autopsy certificate 2 L No 2 No 1 ☐ Yes 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by t death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

To the I within 2. To the F DaN 10

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

Year) 31. Date filed (Month, Day,

30. Name and address of person who completed

29b. Signature and title of certifier

Registrar's Signature

29d. Date signed (Month, Day, Year), 9

Hospital Drive, Glen Gorgnie,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 0 Norceste, 5. Social Security Number 6. Sex Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days Months Hours Min 1 M 2 □ F 229-39-768 Usual Residence of Decedent Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ATYes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 73 d Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ 3 Widowed 4 □ Divorced er than "natura , the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 31-0 Grade 17. Father's Name (First, Middle, Last) Operator 119hn 18. Mother's Name (First, Middle, Maiden Surname) other Be it of Health and Mentalitiem 27 is marked or other traumatic ev ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) armoni 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it any injury or or 1 Burial 2 Cremation 3 Removal from State Dover 4 ☐ Donation 5 Other (Specify) 10-11-09 remation 22. Name and Address of Facility Bennic Smith Funcrol Hom. 21 Signature of Funeral Service Licenses POCOmoka 10x331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTERIOSCIENOTIC Canpiovasulan Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an the funeral director, page 2: autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ★Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who of eted cause of death (Item 23a) (Type, Print) BAI Pocomoke City

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**OCT 09** 

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year OWARD HARL TOBER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death If Under 24 Hrs. DOMERFORD If Under 1 Year Date of Birth (Month, Day, Year) 1/6/1929 9. Birti Cou 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 X M 2 □ F Maryland 80 216-24-9022 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2X No Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 1744 Tacoma Rd. 21037 12. Was Decedent Ever in U.S. Armed Forces? 1 X X es 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XXNo Specify White Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 1955-75 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Navy Elementary/Secondary (0-12) College (1-4or 5+) Administrator 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary A. Parr Luther Elmer Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

1744 Tacoma Road, Edgewater, Maryland 21037

10/7/09

22. Name and Address of Facility George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes

2 No

28d. Describe how injury occurred

24a. Was an

1 □ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Approximate Interval Between Onset and Death

OYPARK

Year

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

ASSISTED

LIVIA

Edgewater, MD

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it e Mailicel Examination.

**Physician** 

**Examiner** 

**Funeral** 

Director

28a-f show

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or items 23a

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Director

Funeral

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Completed

Be

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19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cense

Moni

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Unicerying Cause (Disease or injury that initiated events

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

5 Pending investigation

6 Could not be determined

1∐ Yes 2 ☑ No

examiner?

27. Manner of Death

1 Natural

2 Accident

4 🗌 Homicide

(Check only

29b. Signature and title of certifier

3 Suicide

29a. Certifier

resulting in death) Last

IF FEMALE:

disease or condition resulting in death)

Denise A. Millett/Daughter

1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State

traumatic event, if a Medical Examiner must be notified at

/Medical

10a. State

Physician /Medical **Examiner** 

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

burialthe as s been signed be should be deta

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death. After within 24 hours after death To the Funeral Director:

July 14. Ten Mis	D46360	CCTOBER 6,	2009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11		
MICHAEL A. ANKROM MD 8	LI Verorians HIG	HWAY MILLOWSVILL	LE MOZINS
31. Date filed (Month, Day, Year) 32. Registrar's Signature		, , ,	
31. Date filed (Month, Day, Year)  OCT 07 2009  August A. August	,		

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy

5 Other (specify)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per phys. G897 11/9/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 | 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:10 2009 22 IZABETH /tADDAWAT /Medical 4b. City, Town, or Location of Death 4c. County of Death 21620 Name (If not institution, give street and number) Examiner KENT HESTER RIVER MD MANER HESTERTOWN 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Days Months Min. 219 055197 Yrs. MARCH 10, 1921 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Director HESTERTUNI 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21620 MORGNEC ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MASON KOSE 706WELL ARTHUR AROLINE JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ( 478 19a. Informant's Name/Relationship (Type. Print) GROVE ROAD Department of Health a Important: If item 27 is any Injury or other tra PURTERS WOETOW, MD (= WYNN 2 Date 20c. Location - City or Town, State 20a. Method of Disposition 21620 Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTERTOWN Name and Address of Facility
OF CREED HERE 126/09 MD 22. Name and Address 21. Signature of Juneral Service Licenses CHESTERTOUN, MD 2/620 MARVIN V. WILLIAMS JR Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Newson Q a disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as ding IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ned by the a O 9□Unknown 9 Unknown signed by t ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ TEART 5 VE 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perforn certificate 2X□ No 1□ Yes or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Many r of Death 1 Natural 28a. Date of Injury (Month, Day Year) ne Hospital or Attending P n 24 hours after death. he Funeral Director: After t 28b. Time of 28d. Describe how injury occurred Injury at Work? After Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 2 Medical Examin one) d manner stated. To the l within 2-29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 31. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State CED 24 2000 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician /Medical Year September Harris 2255 PM 27 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day | 1/25 | Social Security Number Birthplace (State Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F 221-38-952 Director Mary I and Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 1X Yes 2 ☐ No DE Kent 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 99 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify. þ Specify: Black Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT Elementary/Secondary (0-12) College (1-4 or 5+) ocia OrK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 မ ood ley 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S. to Department of Health ar Important: If Item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dover, 21. Signature of Funeral Service Licensee Division St. Dover, DE mmie 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Du to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events physician and is the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 400 9 Unknown signed by t Id be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b director, page 2 s autopsy performed? 2 No 2 -1 Tyes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 2 □ No 1 Minpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day ) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 2 Accident 1 Yes 2 🗌 No filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 9 - 27 - 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

as Kent

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

NIESSEN

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Physician	į
/Medica	l
Examine	į

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Evantinar must be retified at angle."

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Stat Registra

	1 - State Registrar		i mai yiain		ertificat			ina me	Re	g. N.2	009	34213	
_	1. Decedent's Name (First, Middle	le, Last)						2	2. Date of Death Month			3. Time of Death	
n al	SAMUEL GEORGE	HURLOCK							OCTOBER			2:35 A M	
er	4a. Facility Name (If not institution	-	7		Location of	Death			ounty of Deat ENT	h			
	CHESTER RIVER  5. Social Security Number			ast hirthday			RTOWN  If Under 2	4 Hrs.   p	B. Date of Birth			hplace (State or Foreign	
	186-14-8786 Usual Residence of Decedent	1 M 2 □ F	85	Months Days Hours Min.				Min.	8. Date of Birth (Month, Pay, Year) 7/31/1924 9. Birthplace (State or For Country) MD				
ctor	MD CECIL NORTH EAST											1 □Yes 2 No	
Öire	10e. Street and Number				10f. Zip				10	-	n of What Co	untry?	
La	241 IRISH TOWN RD. 21901 USA												
Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	rried Armed For	2 No	If Yes, specify Cuban', Mexican, Puerto Rican, etc.)  Black,  1 □ Yes 2 ᠯ No Specify: Snecify:						. Race - Ame Black, White pecify: WH			
etec	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dec	edent's Usua e kind of wo DO NOT us	al Occupa rk done d	ation Juring most	of working	7	6b. Kind	of Business/	Industry	
ם	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT US EST RA					СТАТ	F OF M	IARYLAND	
ပ္တို	17. Father's Name (First, Middle,	Last)		FORK	LOI IV			's Name (	First, Middle, M			MICI DENICE	
To B	SAMUEL DAVID						HILD	OA VI	RGINIA	BRIN	SFIELD	)	
-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip											Zip Code)	
	JUDY TRUITT/DA	AUGHTER		1				INGL	ESIDE,				
	20a. Method of Disposition  1		Siale		Disposition (Name of pare) CON CEMETERY  Date  10/17/09					20c. Location - City or Town, State  CRUMPTON, MD			
	21. Signature of Funeral Service	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 W. CYPRESS ST. MILLINGTON, MD 21651											
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between	
	Immediate Cause (Final disease or condition DEMENTIA										Onset and Death		
	resulting in death)  Due to (or as a consequence of):											0 1777	
er	Sequentially list conditions, lift any leading to immediate  b. DEHYDRATION  Due to (or as a consequence of):											2 WKS.	
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.												
Medical Examiner	resulting in death) Last	Due to (	or as a consequ	ience of):									
ica		d											
Med	IF FEMALE:	20. 16											
Be Completed by Physician/N	23b. Was decedent pregnant in the past 12 months?  1											livery Day Year	
y Ph	Part II. Other significant conditi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute											
d b	CHRONIC RENAL	INSUFFICI	ENCY, A	CRIAL	FIBRI	LLAT	ION		1 □ Ye	1 ☐ Yes 2 📉 No 3 ☐ Probably 4 🗆 U:			
plete	UPPER 01 BLEED		24a. Was ar		24b. Were au	utopsy findings available							
Ĕ									perform	performed? death'		completion of cause of	
Se C	25. Was case referred to medica examiner?						26. Place	of Death	(Check only one	<u>.</u>			
2	1 Yes 2 No				ent 3 D		4 LI Nur		e 5 🗆 Reside			ecify)	
io iii	1 XNatural 5 ☐ Pendin												
2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Str.								Street and Number or Rural Route Number,					
ertii	4 ☐ Homicide determ	determined 1266, Place of Injury - At nome, farm, street, factory, office 1261, Location (Street and Number of											
Medical Certification: To	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
Me	29b. Signature and title of certifie	29c. License number					d. Date	signed (Mont	th, Day, Year)				
	1	)	D51735					10/14/09					
	30. Name and address of person FREDERICK W.				e, Print)			ESTER	RTOWN, N				
e	31. Date filed (Month, Day, Year,		tegistrar's Signa		1								
ar	UCT	16 2009	March .	4.	BOOK								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 MICHAEL FRANKLIN HINEFELT OCTOBER 1:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5951 ROCK HALL ROAD KENT ROCK HALL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Months Days Hours Min 12/11/1957 Director 217-74-7544 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD KENT ROCK HALL 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral **USA** 5951 ROCK HALL RD. 21661 or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 XMarried Yes 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give "natural", Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) PILE DRIVER MARINE CONSTRUCTION 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PATRICIA LEE JEFFERS <u>ALFRED FRANKLIN HINEFELT</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH M. HINEFELT/WIFE 5951 ROCK HALL RD. ROCK HALL, MD 21661 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/7/09 STEVENSVILLE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS. HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 any Kul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ STAGE disease or condition resulting in death) MAL Medical Due to (or as a consequence of) Examiner disentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury death certificate be executed burial-transit YPE -R-T and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical VASCULAR DIBEASE Box 68760 as the l attending IF FEMALE e esn. yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year the detached 9 Unknown Ö by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be c Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has autopsy performed? 1 ☐ Yes 2 No Yes 2 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 WN မ 1 Tyes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Matural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the

State

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item

32. Reg

strar's Signature

F. Ciganek

23a) (Type, Print)

29c. License number

696 Railroad the Centreville, MD 21617

29d. Date signed (Month. Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. October 4, 2009 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

State Registrar Pamela E. Southall, MD

(Month, Day, Yea

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 10, 2009 William 11:52 pM George Kerns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 15910 Woods Center Road Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min XXM 2 F Maryĺand 578-16-1269 93 23, 1916 Director Jan. Usual Residence of Decedent f show 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20906 USA 15910 Woods Center Road death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc within 72 hours after 1 XYes 2 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: WWII era 1 ☐ Yes 2 💆 No Specify þ Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene item 27 is marked other than "other traumatic event, itte "Max Elementary/Secondary (0-12) College (1-4or 5+) Naval Hospital Maintenance Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Herbert Kerns Margaret Schriver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Robert W. Kerns/Son 18723 Birdseye Drive, Germantown, MD 20874 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. Parklawn Memorial Park 2009 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 2090 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. Cerebrovacular Accident 3 weeks disease or condition resulting in death) , /Medical Due to (or as a consequence of): Examiner 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Hypertension Examiner Due to (or as a consequence of) certificate be executed burial-transi and Due to (or as a consequence of): physician sthe burial Box 68760, Physician/Medical attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö the 1 □Yes 2 □ No. 9 Unknown signed by to σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate hes page 2 autopsy perform 1 ☐ Yes 2 No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this After the 27 Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 X Natural 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐ No ours after death eral Director; filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 12, 2009 D47682 Morus 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Road, Olney, MD 20832 Bennett Morrison, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

		Please Type						-		•	
		For State State Registrar	ate of Ma	aryland		partment of F ertificate of		1ental Hy		009	34217
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Dorothy  L.	Ker	nnedy				2. Date of De Month Octobe	eath	, 2009	3. Time of Death 10:45p M
Examin Funeral Director		4a. Facility Name (If not institution, give street 3618 Littledale Road 5. Social Security Number 6. Sex 1 □ M 2	7. Ag	2B e (In yrs. la	st birthda Yrs.	Ken	sington If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Feb. 2	rth ay, Year)	9. Birth Cou	gomery place (State or Foreign ntry) Georgia
show	٠	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or	Location			-		10d. Inside City Limits
the Ma	Director	Maryland Montgomery  10e. Street and Number	7		Ker	nsington 10f. Zip Code			10g. Citi	zen of What Cou	1 ☐ Yes 2 🛣 No ntry?
ath with		3618 Littledale F				2089!				SA	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show alcot Examinate or rediffed at	by Funeral	1 Never Married 2 Married	as Decedent med Forces? Yes 2 ☐ I 'es, Give ar or Dates:			3. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Whit	etc.
I within 72 hou jiene. r than "natura In the field.	Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12)	oleted) illege (1-4or 5	i+)	(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired	during most of worki	ing	16b. Kii	nd of Business/Ir	idustry
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nd 2 should be filed within alth and Mental Hygienal Hygiena 27 is marked other than "	To Be	Roy Greenwood					Grace P	•	, maidon		
nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Type. Pr John D. Kennedy/Son	int)			iling Address (Street Sansbury			-		o Code)
permit. Pages 1 and 2. Department of Health a Important: if item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	al from State	20b. Pla	ice of Dis metery, ci	position (Name of rematory or other place	ce) OC	)ate t. 12		cation - City or To	own, State
mit. Pa bartmen oortant: injury ee.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		Metr	-	.itan Crem 22. Name and Addre	7 2	009			a, Virginia
		James & S	Dece	<i>a</i>		22. Name and Addre Francis 500 Unive				Home Inder Sprin	
Physician		resulting in death)	se on each lir	ne. Lve He	art	Failure	ng, such as cardiac (	or respiratory a	arrest,		Approximate Interval Between Onset and Death 3 years
Examiner	<u>.</u>	At	rial E	ibril	lati	.on					4 years
sician and burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Oue to (or as								
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es the signer in the design of	ক্র	Part II. Other significant conditions contributi Spinal Stenosis, Lum		ut not result	ing in the	underlying cause giv	en in Part I.				the cause of death?
i: The law re icate has be ; page 2 sho	Completed							24a. Was auto perfo 1 🗆 Yes		prior to co	opsy findings available ompletion of cause of 2  ☐No
ysician is certifi director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita	il: 1 ☐ Inpatie	ent 2 □ E	R/Outpat	ient 3 □ DOA Oth	26. Place of Death er: 4 ☐ Nursing Ho			6 □Other (Speci	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: 1	27. Manner of Death  1	a. Date of Inju (Month, Da	ry y, Year)	8b. Time Injury	/ Wor		28d. Describe			
al or At s after d il Direct	Sertifi	4 Homicide determined 286	e. Place of Inju building, etc	ury - At hom c. <i>(Sp</i> ec <i>ify)</i>	ne, farm, :	street, factory, office	i	28f. Location ( City or To	Street and wn, State,	d Number or Run )	al Route Number,
the Hospital hin 24 hours a the Funeral I	edical	29a. Certifier (Check only one)    Certifying Physician   2   Medical Examiner: Cartifying Physician   2   Medi	To the best in the basis o and manner sta	f examination	ledge, de on and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occuri	and due to the red at the time	cause(s) , date and	and manner as I place, and due t	stated. to the cause(s)
V with	Σ	29b. Signature and title of certifier  Nelua J. Ah	apur	B		29c. Licens D3 5				e signed (Month, tober 12	
		30. Name and address of person who complete Deena Shapiro				e, Print) onnecticu	t Avenue,	Kensin	gton	, MD 208	395
Stat Registra		31. Date filed (Month, Day, Year)  OCT 13 2009	22. Registra						-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2359 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Riva Terrace III Assisted Living Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/17/1909 9. Birthplace (State or Foreign 6. Sex 14 M 2 □ F **Funeral** Days Hours England 169-10-6387 100 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Event entitle to recitified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√∑ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1680 North Winchester Road 21409 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Knight Charlotte Unwin ပ္ 19a. Informant's Name/Relationship (Type. Print) Cicely Knight/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1680 North Winchester Road, Annapolis, Maryland 21409 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 10/02/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fune Se vice Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23 fart 1. Earler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm Mate Cause (Final BSIELLA **Physician** RO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1 ☐ Yes ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? FERMA Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2☑No Other: 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

State

29b. Signature and title of certifier

wa

Name and address of pelson who

DHMH 17 Rev 1/2001

Registrar

npleted cause of death (Item 23a) (Type, Print)

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Registra

6H WAY ANNAPOLIS MOZIHOI

			For.	State of Maryla		•		, ,		
			1 - State Registrar			Certificate of	Death		Reg. No 200	9 34219
	Physici	an	1. Decedent's Name (First, Middle, Last)	a / i				2. Date of Dea Month	Day Ye	3. Time of Death
· ·	/Medi		4a. Facility Name (If not institution, give	Kukan	1	Ab Cibe Town	or Location of De			<u>09</u> 1305 M
	Examir	ner	Chastar R. Wax I	Las oits (	ant	4b. City, Town,	c Lack	eatn	4c. County of I	Death
	Funeral		5. Social Security Number 6. Sex		rs. last birt		If Under 24 H		h (9.	Birthplace (State or Foreign
	Director		138-26-5353	]M 2□ <b>X</b> F 1	02	rs. Months Days	Hours M	12/13/	1906	Country) IA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c	City Town	or Location				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	uid be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show attc event, the Medical Evaminar must be notified at	alD	32281 QUINN RD.			21650			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces2	ı U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian, Vhite, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐Yes 2 ZNo If Yes, Give		1 ∐Yes 2 🛣 No		, , , , , , , , , , , , , , , , , , , ,		WHITE
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<u> </u>	2 should be filed within n and Mental Hygiene. Is marked other than raumatic event, It all the second of the secon	1º	MATTHEW GREENE					OR GEHLE		
altimore, Maryland 21215-0036	d 2 s th ar th ar trau		19a. Informant's Name/Relationship (Ty) DON KUKAN/ SON	pe. Print)		Mailing Address (Street			r, City or Town, Sta	ite, Zip Code)
ē,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti		20a. Method of Disposition	201	o. Place of	BOX 62 MAS  Disposition (Name of	1	21630 Date	20c. Location - City	y or Town, State
E E	Pages nent of int: If ite iry or o		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)			crematory or other pla CEMETERY		/1/09	GALENA,	MD
a	permit. Departm Importa any inju		21. Signature of Funeral Service License		UUTINU	22. Name and Addre				
<u> </u>	8 9 E 8 8		Gran Fellans			130 SPEER	RD. CHE	IN & NEWN. STERTOWN,	MD 21620	L HOME
			23a. Bert 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de le cause on each line.	eath. Do n	ot enter the mode of dy	ing, such as card	iac or respiratory are	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sepsis	5					48 low =
-	/Medical Examiner		resulting in death)	Due to (or as a cons	equence o	n):				,
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence o	n:				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or irijury that initiated events							44
Ö,	e exe ian ar urial-t		resulting in death) Last	Due to (or as a cons	equence of	f):				
8760	requires that the death certificate be executed teen signed by the attending physician and nould be detached for use as the burial-transit	dical	d							
× 6	certifi iding p	/Me	IF FEMALE:	3c. If yes, outcome of prec	anancı/					
Box	death atter	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of Month	delivery Day Year
7. O	t the c by the achec	hysi	1 ☐ Yes 2 M No 9 ☐ Unknown	9 ☐ Unknown						
Š,	es tha gned se det		Part II. Other significant conditions con	tributing to death but not re	esulting in	the underlying cause given	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
o G	w requires that the death certifice been signed by the attending should be detached for use as	ted	Zmphypana / Hi	Story SICH	f	<del></del>		_ 1 🗆 Y	es 2 □ No 3 <b>∦</b>	Probably 4 Unknown
ပ္မ	> 4 70	Completed by						24a. Was a	sy prior	e autopsy findings available to completion of cause of
	ician: The lav certificate has ector, page 2 a							perfòr 1 □ Yes	med? deat 2.20 No 1 □	
VITa	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		ogtiont 2 DOA Oth		eath (Check only or		
ō	y Phy er this eral di	<u>ان</u>	1 ☐ Yes 2 📉 No 27. Manner of Death	1 12 Inpatient 2 28a. Date of Injury	28b. Ti	me of 28c. Inju	4 LI Nursing	Home 5 ☐ Resid	ence 6 Other (	Specify)
<u> </u>	ah. T. Afte e fun	atio	t∭ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	) Inj		rkí? ∐Yes 2. ∐No		,,	
UIVISION	r Atte er dez recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farr	n, street, factory, office		28f. Location (Si City or Town	treet and Number o	r Rural Route Number,
5	ital o ral Di lled in									
	To the Hospital or Attending Physician: within 24 hours a ler dear. To the Funeral Lirector After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Phys Medical Examin	ician: To the best of my k	nowledge, ination and	death occurred at the ti /or investigation, in my	ime, date and pla opinion, death oc	ice, and due to the c curred at the time, o	ause(s) and manne late and place, and	er as stated. due to the cause(s)
	o the vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			9d. Date signed (M	
			) The age	P)		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	50996		9/20/10	7
	3		30. Name and a ress of person who con	mpleted cause of death (It	tem 23a) (T		- / / @		1-110	

State Registrar

Dei (Staddard MD

31. Date filed (Month, Day, Year)

32. R

100 Brown St - Clastertaum MD 21620
32. Registrar's Signature A. par OCT 0 2 2009 > Serve

			State of Marylan		artment of F		Mental Hygie	ne 2009	34220
	_		Registrar  1. Decedent's Name (First, Middle, Last)		inicate or	Death	2. Date of Death	Nag U U J	3. Time of Death
н	Physici /Medi		DORIS ANN		LUCKETT	3	October 9	Pay 2009 Year	2:27A. M
AR.	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Death	<u> </u>	4c. County of Death	
P			Doctors Community Hospital		Lanh			Prince Ge	
	Funeral Director		5. Social Security Number 577–42–9854 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yang) Aug • 4 , 19	32 Wash	place (State or Foreign htry) ington, DC
	pur 🚜		Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or Lo	agtion				0d. Inside City Limits
	Maryla f sho	o		eenbel					1 Yes 2 No
	r 28a-	irect	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	th witl	al D	8108 Lakecrest Drive		2077	0	Ţ	Jnited Sta	tes
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar must be notified anone.	Completed by Funeral Director	11. Marital Status  1 □ Never Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in UArmed Forces?  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 □Yes 2 🛣 No	ispanic Origin? (Span, Mexican, Puerto Specify:	oecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
2-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation		o. Kind of Business/In	
121	vithin ne. <b>han</b> "	nple.	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done o	i)	-	erating Er	ngineers
d 2	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	Secre	tary	18 Mother's Nam	Un ne (First, Middle, Mai	ion	
<u>a</u> n	ld be lental ked o ic eve	To Be	George Taylor Luckett				ouise Dick	,	
ary	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)					ity or Town, State, Zij	
Σ,	and 2 lealth m 27 i		Michael W. Goodman -son					Maryland	
Baltimore,	iges 1 nt of H if ite or otl				sition (Name of natory or other place			c. Location - City or To	
Ħ	nit. Pa artmer ortant: injury	5	4 □ Donation 5 □ Other (Specify) Me  21. Signature 1 unital Service Licensee		_			lexandria,	_
Ba	permit Depar Impor any in		er Will centre	44	onaid V. 400 Powde	Börgward r Mill Ro	t Funeral oad Beltsv	Home, PA ville, Mar	y1and20705
			23a. Part 1. Enter the disease, or complications that caused the dea shock, a heart failure. List only one cause on each line.	th. Do not ente	er the mode of dyir	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition resulting in death)  Cancer of	Lung					Onset and Death  1 year
1	/Medical Examiner		Due to (or as a consec	quence of):					
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5	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter in a dyin. Cause (Disease or injury that initiated events c						
, 0,	ficate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as a consec	quence of):					
8760,	icate l physi	dical	d						
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥No 9 □ Unknown  23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 ⊑	Ectopic pregnancy Other <i>(specify)</i>	<b>y</b>		23d. Date of deliv Month	ery Day Year
s, T	s that gned b	y P	Part II. Other significant conditions contributing to death but not res	sulting in the un	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
brd	w requires that s been signed l should be det	ted t	Hypothyroidism				1 X Yes	2 No 3 Pro	oably 4 Unknown
Division of Vital Records,	hysician: The law r his certificate has bo I director, page 2 sh	Completed by					24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to co	psy findings available mpletion of cause of 2 XNo
<u> </u>	sician certif rector	Be	25. Was case referred to medical examiner?  Hospital: ####################################		t 3 DOA Othe	ar:	th (Check only one)		
o o	g Phy erthis eral d	n: To	1 ☐ Yes 2 【XNo 1 ☐ 1 【X Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injur	y at	ome 5 ☐ Residenc 28d. Describe how i	e 6 ☐ Other (Special njury occurred	<u>(y)</u>
ioi	eath.	atio	1 ☑Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	M 1 🗆	?? Yes 2 □ No			
<u>X</u>	I or Attending Ph after death. Director: After th i in by the funeral	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
_	he Hospital in 24 hours in he Funeral pletely filled	Medical Ce	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my kn 2 ★ Medical Examiner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tir vestigation, in my o	ne, date and place pinion, death occur	, and due to the caus rred at the time, date	se(s) and manner as a and place, and due to	stated. the cause(s)
7	P Miles	Σ	29b. Signature and title of certifier		29c. License DO50			Date signed (Month, October 9,	
			30. Name and address of person who completed cause of death (Ite Reva Gill, M.D. 6510 Kenilworth	m 23a) (Type, F Avenue	e,#2400 R	iverdale,	, Maryland	20737	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature face	J.				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral 34221 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Luna 5:12PM 2009 crmin 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore UMMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☑ M 2 🗆 F El Salvador 579-08-8864 42 Director 11-24-1966 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1X Yes 2 □ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1446 Kanawha St. #201 20783 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 X Yes 2 □ No Specify: White Specify. If Yes, Give Year or Dates þ 3 Widowed 4 Divorced salvadoran Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook 4th Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental em 27 is marked o Mercedes Argueta Eugenia Luna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felipe Luna (Uncle) 9006 Cherry Ln. S. Upper Marlboro, MD 20774 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Family Cemetery El Salvador 4 Donation 5 Dother (Specify) 10-17-09 permit. 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. of uneral 5 3447 14th St. N.W. Washington DC 20010. Par /. Enter the disease, or come s ock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** acut esulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sign 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Physician; The certificate performed 1 ☐ Yes 2 No 2 □ No funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending 24 hours after death. Funeral Director; ₽ 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P23072Q 10,06,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Parker 1540 Canton Center Drive Baltimore, Maryland 21227 32. Regis ar's Signature State Registrar

09-07901 Aaron Lewis

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 34222 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 11, 2009 1300 hrs **Medical Examiner** Aaron Donnell Lewis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 214-11-1648 11-22-1971 1X M 2 F 37 Washington, DC Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show Bladensburg notified at once, Md. Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 5200 Quincy Street, #107 20710 U.S.A 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Pages 1 and 2 should be filed within 72 hours after death witnent of Health and Mental Hygiene.
 refairt. It item 27 is marked other than "natural", or items or other trannatic event, the Medical Examiner must be or other trannatic event, the Medical Examiner must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 X No Yes Black Yes 2 No specify: Specify: Divorced If Yes, Give Year ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12th Truck Driver Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clinton Lewis Adrienne Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) MD Adrienne Hall - Mother 5200 Quincy Street, #107 Bladensburg, Md. 20710 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State fimore, crematory or other place) 10-20-2009 Riverdale, Maryland Riverdale Park Crem. Donation 5 Other Specify 22. Name and Address of Facility Ronald Taylor II Funeral Home 21 Signature of Funeral Service Licensee 21201 108 W North Avenue, Baltimore, Maryland T Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each ine /Medical Death Acute combined drug intoxication (cocaine, tramadol Due to (or as a consequence of): alprazolam, doxepin) & narcotic use Immediate Cause (Final disease aminer or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. hysician/Medical 23a,27,28a-f,perME, g897 11/4/09 TT X UNPENDED signed by the attending physician be detached for use as the burial -Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions ⋛ Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, has been s e 2 should b 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: Other, examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 2 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: Natural 1 Yes 2 X No unk Director: Pending Fd 10/11/09 Fd 12:25 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 7 10 Onnen Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dires 3 6 X Could not be Suicide Baltimore found at residence MD determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 12, 2009 O.C.M.E. ep 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD 31. Date filed (Month, Day Ye 0CT, 2 0 2009 32. Register's Sign State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician Day 226 M Delores Jean Lease /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS- Braddack Campus umberland Allegan 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug 10, 3irthplace ( Country) 9. Birthplace (State or Foreign **Funeral** ). 19<u>33</u> 1 □ M 2 □ √ Hours Min 220-28-9539 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Modical Evantina must be nested. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 533 Patterson Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify: þ Specify: 3 ☐Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Super Shoes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Aaron Valentine Ina (Boggs) Valentine ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 Patterson Avenue Cumberland MD 21502 Reuben Lease Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lease Family Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a/Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death Depsis Physician Few weeks /Medical Due to (or as a consequence of): Examiner Fewda Multi organifailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit completely illied in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 OSteoporo sis 1 ☐ Yes 2 ☐ 🗐 3 Probably 4 ☐ Unknown Completed Sence Cyphosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🕅 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Ž√ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

DIL

KENTAVE

. CUMBERLAND, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a.m.D

625

32. Registrar's Signature

HUMA SHAKIL

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

within 2

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

EDSTER

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

7 dren

rar's Signature

60629

29d. Date signed (Month, Pay, Year)

Box 68760, P.0. Division of Vital Records, 24 hours after death Funeral Director;

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

items 23a

death 1 chrm

Director

Funeral

à

Completed

Be

2

Baltimore, Maryland 21215-0036 Pages 1 and 2 should be f 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed by Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural in by the 2 Accident 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Fazh MD D0064 10/8/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mina Fazli, MD, 1801 E. Jefferson Street, Rockville, Maryland 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 13 2009

			1 - For State Registrar	State o	of Maryland		rtment of F tificate of I		nental Hygid Reg	ene 1. No. <b>2 N</b>	09	34226
	Physic /Medi		Decedent's Name (First, Middle William C. McKinl	,					2. Date of Death Month October	Day 10	Year 2009	3. Time of Death
wi 407	Exami		4a. Facility Name (If not institution Union Hospital	-	ımber)		4b. City, Town, or Elkton	Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 178-22-7887	6. Sex / 1 ☑ M 2 ☐ F	7. Age (In yrs. Ia 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) October 15		9. Birthpli Count	ace (State or Foreign try) PA
	with the Maryland 8a or 28a-f show Lbe notified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County PA York  10e. Street and Number  105 Country Ridge	D.		, Town or Loo	10f. Zip Code		10g	g. Citizen of \		od. Inside City Limits 1 □ Yes 2 ☑ No  ry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I as I action Examination is ust by notified at once.	Š	11. Marital Status  1 Never Married 2 Mari 3 Widowed 4 Divorced  15. Deceden (Specify only highe.	12. Was Dec Armed Fr ied 1 ∐Yes If Yes, Gi Year or D	2 ☑ No ve	16a. Deced	Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		wn	ite
12121	Hygiene. Hygiene. Iher than "	Completed	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle,	College (	1-4or 5+)	life. E	y Commissic	oner		Govern		
Maryland	should be f ind Mental I marked of umatic eve	To Be	Joseph J. McKinley  19a. Informant's Name/Relations			19b. Mailin	a Address (Street	Velma E.	e (First, Middle, Ma <b>Shaull</b> al Route Number, O			Cade)
Baftimore, Ma	t. Pages 1 and 2 tment of Health a tant: if Item 27 is jury or other trai		Mary Ellen McKinle 20a. Metylod of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	ey/Wife 3 □ Removal from	State	105 (	Country Ridg lition (Name of atory or other place	e Dr., Red Li	on, PA 1735	56 lc. Location -		vn, State
Bal			21. Si Sature of S rvice 23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that of	aused the death.	. Do not ente	er the mode of dyin	e Funeral Ho	ome, 259 E. Nor respiratory arres	Main St.,		MD 21921 Approximate Interval Between Onset and Death
and the same of th	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to	or as a conseque	ence of	est					minutes minutes
50,	ficate be executed physician and sthe burial-transit	I Examiner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conseque	hable pable	Acute 1	Myo cardos	Infor	repon	0	ne day
P.O. Box 68760	eath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live 4 ☐ Preg 9 ☐ Unkn		death 3 ath 5	Ectopic pregnancy Other (specify)		1	Mo		Day Year
Records,	e law requires that the d has been signed by the je 2 should be detached	by	Part II. Other significant condition	ns contributing to de	eath but not resul	ting in the un	derlying cause give	en in Part I.	23e. Did tobac	J		e cause of death?
итан жес	ate	e Completed	25. Was case referred to medical			_				d?	Were autop prior to com death? 1 □ Yes 2	sy findings available apletion of cause of
VISION OT VI	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	요 일	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date (Mon		R/Outpatient 28b. Time of Injury	28c. Injury Work	at Nursing Ho	me 5 Residence 28d. Describe how			)
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 26e. Place buildi	of Injury - At hom				28f. Location (Stree City or Town, S	State)		
	the Hosp thin 24 hor the Fune impletely fi	Medical	one) 2 Medical E	g Physician: To the Examiner: On the b and man	asis of examinationer stated.	on and/or inv	estigation, in my op	oinion, death occurr	ed at the time, date	and place,	and due to t	the cause(s)
)			30. Name and address of person v	who completed caus organ, Mo 32. R	W J	20a) /T = =	Da	069121	00	Date signed		
	√ V Stat	e.	30. Name and address of person was a series o	who completed caus	e or death (Item 2	re	G. Elka	m mp,	21921		-	
	Registra		nct	1 3 2000	house	A	Marked					

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34228 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9, Day 2009 Year **Physician** Miller Jessie Mae 6:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG St. Thomas More Nursing & Rehab. Cntr Hyattsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11 | -8 - 1921 9. Birthplace (State or Foreign Country)
Wash. DC 5. Social Security Number 578–18–0089 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X ☐ F 87 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at DC Washington 1 □Yes Z No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 855 21st St. NE #10 20002 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{PNo} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc within 72 hours after 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes X□No Specify: Black Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wit.

Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jackson Frances Marshall ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Anita Miller/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 855 21st St. NE #10 Washington DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 11-02-2009 Riverdale Pk Crem. Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 21. Signaty e of Fun-yal Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Vnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 4203 QUEENSDAY

32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCTOBER 12 2029

Hyatis 16 Mis 20781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Thilaga Rajan Manuel State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day October 7, 2009 2225 hrs Medical Examiner Thilaga Rajan Manuel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3813 72nd Avenue Hyattsville Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Director Country) India 12/27/1947 217-70-4533 1 X M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No s 23a or 28a-f shov notified at once. 28a-f show MD Prince George's Landover Hills permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic vent, the Medical Examiner must be notified at ones. rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country ä 3813 72nd Avenue 20784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Armed Forces Yes 2 X No Widowed If Yes, Give Year Yes 2 X No specify: Indian Divorced Specify: þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 4 Accountant Accounting 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aruganoy-Gum Manuel Nissam Moneveil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 19a. Informant's Name/Relationship (Type, Print ) Patricia Norris Manuel/Wife Fox Chase Rehab Cntr., 2015 East-West Hwy., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Date Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/13/09 Alexandria, Virginia Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 tons ance Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Complications of Chronic Alcohol Abuse Immediate Cause (Final disease **⊏**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 V Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 8, 2009 30. Name and address of person who completed cause of death (Item 23a)

State Registrar DHMH 17 Rev 1/2001

CICME 2006

Jack Titus MD.

Date filed (Month

111 Penn Street, Baltimore, MD 21201

Deputy Chief Medical Examiner

32. Registra's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan		rtificate of		ivientai myt	Reg. No. 2009	34230
	Physici	an	1. Decedent's Name (First, Middle, La	· ·				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	cal	Joan Add  4a. Facility Name (If not institution, gir	15 McCon	)(	Ab City Town o	r Location of Dea		ber 27 260 4c. County, of Dea	
1	Examin	ier	Chester River	Hospital		Cheste	1	MDale	i 1/	7
	Funeral		Social Security Number     6.	Sex 7. Age (In yrs. 1 \( \text{ Age } \)		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	h 9. Bi	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	82	Yrs.			Nov 20	0/926	FT
	ryland how	_	10a. State 10b. County		ty, Town or Lo		,			10d. Inside City Limits
	he Ma 28a-f s	Director	MD KE	UT	CHES	TERTOW	· ~		10 000	1 ☐ Yes 2 No
	with t	ij	10e. Street and Number  220 RADCU	FFE DRIVE		10f. Zip Code	620		10g. Citizen of What C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evertiner rout be notified at once.	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Was Decedent of H	-	Specify Yes or No-		erican Indian,
36	s after , or ite	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		l □Yes 2 <b>X</b> No	Specify:	to Filoan, etc.)	Specify: U	
21215-0036	hours atural'	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	16a. Deced	dent's Usual Occup	oation	I	16b. Kind of Business	
212	thin 72 ie. an "na	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done OO NOT use retired	during most of wa	rking	1	
2	filed wi Hygier <b>ither th</b>	S	12	1+	TRI	AVEL A	CENT 18 Matheria No	ma (Eirat Middla	TRAVE	
and	d be fi ental I ked ot c ever	o Be	17. Father's Name (First, Middle, Last	TAMES AS	· ** / 4		1/	biN14	Down	ES
Maryland	should and Mer s marke tumatic	2	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street			er, City or Town, State,	
	and 2 lealth a m 27 is		SALLY MCCOUN	HARDING	201		AMPUS		ESTERTOW	
See.	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □	Hemovai nom State	Place of Dispos cemetery, cren	sition (Name of natory or other plac		Date	20c. Location - City o	
Baltimore,	artmel ortant Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	·	E.S.APEA1	Name and Addre	4 6 4		CHESTER	
ñ	permit. Departimontal		Mari VW	ile_D					extour MD	
П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the death	h. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. I'neura	mea					Onset and Death
-	/Medical Examiner		1	Due to (or as a consequ	uence of):					
	p +	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b Due to (or as a consequ	uence of):					
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ						
68760,	ficate be executed physician and s the burial-transit		in death, and	. Due to (or as a consequ	uence oi):					
289		ledical		d						
Box		Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	ev.		23d. Date of d	,
o	he des the at	ysici	1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (specify) _			Month	Day Year
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မွ	e law re has be e 2 sho	Completed	Atrial from	lation, AS	SCVD			24a. Was a	an 24b. Were a prior to death?	utopsy findings available completion of cause of
_	ician: The l certificate ha ector, page		Congostroe	Heart faction	ı			perfor 1 □Yes	rmed? 🗼 death?	s 2□No
\Ita		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Lopatient 2 ☐	EB/Outpation	t 3 DOA Oth	or.	ath (Check only of	ne) Ience 6 □Other (Sp	
	ng Phy terthia neral c	i T	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	1 0 1 00,1	ry at	1	ow injury occurred	еспу)
S	Attending r death. ector; After by the fune	catic	1	n		M 1□	Yes 2 No			
Division	lor At after d Direct I in by	Certification: T	4 Homicide determined		ome, farm, stre fy)	eet, factory, office		28f. Location (S City or Tow	Street and Number or F n, State)	Rural Route Number,
	ospita hours ineral y filled		29a. Certifier 1 Certifying Pl	hysician: To the best of my kno	wledge, death	n occurred at the ti	me, date and place	e, and due to the	cause(s) and manner	as stated.
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	one)	miner: On the basis of examina and manner stated.	ation and/or inv					
		2	29b. Signature and title of certifier	10		29c. Licens			29d. Date signed (Mor	nth, Day, Year)
	10		30. Name and address of person who	completed cause of death (Item	n 23a) (Type. F	Print)	01703	6	912810	7

State Registrar

Sugar K. Ross M.D. 516 Woshing for Are. Clustator Md 21620 32. Registrar's Signature

1775-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** October 2009 1030PM Kichard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Chestertown Md21620 hester Kent Kiver If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Mgnth, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1**X**M 2□ F 534284620 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show CHESTERTOWN MD 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or : RADCLIFFE U.S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No 1 Mes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1943 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 1945 "natural", 27 Is marked other than "natur traumatic event, the Model 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SURANCE TGENT 17. Father's Name (First, Middle, Last) Be Mc Cown ပ NDREW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AVENUL HARDING E. CAMPLIS CHESTERTOWN, MD 20a. Method of Disposition
1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date Department of h Important: If Ite any injury or ot once. 3/09 4 ☐ Donation 5 ☐ Other (Specify) HESTER, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line.

Immediate Cause (Final disease or condition respiratory arrest, shock). Mo 2/120 CHESTER TOWN, Approximate Interval Between Onset and Death Physician neumma disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by tre Cordioros actor 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Hospital or Attending Physiclan: The hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 THO Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Washing

0

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1833

29c. License number

D0017036

29d. Date signed (Month, Day, Year)

Ave. Cleanton Md 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, per am of Maryland Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Clyde Jackson Miller 2. Date of Death Year **Physician** 0720 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15590 Peach Walker Drive Bowie Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. Nov. 17, 9. Birthplace (State or Foreign Country) 1918 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**Z** M 2□ F 90 Director 234-28-6873 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Prince George's Seat Pleasant 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6012 Addison Road 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ≥ Specify. 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Painter Self Employed 17. Father's Name (First, Middle, Last)

Manderville 18. Mother's Name (First, Middle, Maiden Surname) Be Mandrel Miller Mary Toney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. Fred Miller/ Son 15507 Hall Road Mitchellville, MD 20716 20b. Place of Disposition (Name of St. Barnabas
Episcopal Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 10/8/09 4 ☐ Donation 5 ☐ Other (Specify) Upper Marlboro 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 7 Days Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner End Stage Dementia Years Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burlal-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 □Yes 2 □ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760, P.O. Division of Vital Records, after death.

I Director: After the bythe funera filled in by To the Hospital within 24 hours a To the Funeral Completely filled

altimore, Maryland 21215-0036

Hip

Medical

State Registrar

29a. Certifier

(Check only

295. Signature and title of certifier

M W 44) V 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

🗖 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

**Funera** Directo

Physic /Med Exami For

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Empirier must be notified at once. **Physician** 

Baltimore, Maryland 21215-0036

/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

HAH 3 State Registrar

	Registrar	Cer	tificate of Dea	in	Reg. No.	•	
ian	1. Decedent's Name (First, Middle, Last)  ALFRED, W, OW	ENS		2. Date of Month		2000	3. Time of Death
ner	University of Many land Med	lical Center	4b. City Town, or Locati	nove		N/A	nplace (State or Foreign
	121-16-6307 <sup>1∑M 2□F</sup>	(In yrs. last birthday) 81 Yrs.	Months Days Hou	urs Min. (Mont Mar	of Birth h, Day, Year) 22 19	Cot	yland
	Usual Residence of Decedent	10c. City, Town or Loc	-41				10d. Inside City Limits
Director	Maryland Anne Arundel	Annapol					1 □ Yes 2 No
iro	10e. Street and Number		10f. Zip Code		10g. Cit	izen of What Co	untry?
	130 Hearne Rd. Apt 515		21401			USA	
Firmeral	11, Marital Status 12. Was Decedent E	ver in U.S. 13. V	Vas Decedent of Hispanio Yes, specify Cuban, Mex	c Origin? (Specify Yes	or No-	14. Race - Amer	
تَ	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ N	0			i.)	Black, White	
٤	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	□Yes 2¶No Spe	ecity:		Specify: B1	.ack
Re Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation	most of working	16b. K	ind of Business/I	ndustry
a lu	Elementary/Secondary (0-12) College (1-4or 5-	'life [	OO NOT use retired)	mode of Working			
٥	9th 0	Fur	niture Mov			rniture	Co.
To Be				Mother's Name <i>(First, M</i> argaret Qi		Surname)	
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street and No	umber or Rural Route N	lumber, City o	or Town, State, Z	Zip Code)
	Sheila Chambers(Cousin)		Beaver Ro	d. Glen	Burnie	∍, Md.	21061
	20a. Method of Disposition	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Date		ocation - City or	
	1 ☐ Burial 2 【★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro C	rematory	10-6-09	Ba:	ltimore	e, Mđ.
	21. Signature of Funeral Service Licensee		nivame ReAddress of 8				
	Javry B, Seese MOSE 8	3 8	21 West St	t. Annapo	lis, N	Md. 214	101
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dying, suc	h as cardiac or respirat	ory arrest,		Approximate Interval Between
ı	Immediate Cause (Final disease or condition	mant N	enologin	Of-HAO.	11/01		Onset and Death
ı	resulting in death)	consequence of):	COP WEAT	00 1042	IIV		2/14/3
	Sequentially list conditions b. Sep51	5					Zaays
Fyaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
Fyan	resulting in death) Last	consequence of):					
n/Medical	d						
Mer	IF FEMALE:						
/ue	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth	of pregnancy 2 □ Fetal death 3 □	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
10	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown	time of death 5	Other (specify)			WOTH	Day (Cal
hy Physicia	9 Unknown			220	Did tabassa	contributo to	the equal of death?
3	Part II. Other significant conditions contributing to death bu	t not resulting in the ur	iderlying cause given in F	Part I. 23e.		\	the cause of death?
7	4444				1 ☐ Yes 2	No 3□ Pr	robably 4 Unknown
9				24a.	Was an autopsy	24b. Were au	topsy findings available completion of cause of
Completed				1 🗆 '	performed.	death?	2 □ No
Re	25. Was case referred to medical		26. F	Place of Death (Check	only one)		
		nt 2 ER/Outpatien	t 3 DOA Other: 4[	☐ Nursing Home 5 ☐	Residence	6 ☐ Other (Spe	cify)
2	27. Manner of Death 28a. Date of Injur 1 Natural 5 □ Pending (Month, Day		Work?	28d. Des	cribe how inju	ry occurred	
140	2 Accident investigation		M 1 ☐ Yes				
artifi,	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . <i>(Specify)</i>	eet, factory, office	28f. Loca City	tion (Street ar or Town, State	nd Number or Ru e)	ural Route Number,
2	29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred at the time, da	ate and place, and due	to the cause(s	s) and manner a	s stated.
Medical Certification: To	(Check only 2 Medical Examiner: On the basis of and manner sta	examination and/or in					
Me	29b. Signature and title of certifier		29c. License num	ber		ate signed (Mont	h, Day, Year)
	DamleSa	et_	176	199	oct	-,01,	2009
	30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	South by	eene St	Balt	timpre	MD 2120
ate trar	OCT 06 2000 V	r's Signature	bake				
	Cen	70.7	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 Month **Physician** John Parker 11:35pm 10 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HeartFields Assisted Living Prince George Bowie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Months M 2 F 408-14-9327 Director 90 10/10/19 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercises. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No Lanham Prince George Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9217 Moorly Road 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Yes 2 No 1942-If Yes, Give 1942-Year or Dates: 1945 1 Never Married 2 Married Specify: White 1 □Yes 🏖 No \$ 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Proofreader 4years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lon Parker Hattie Irene Reynolds ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 807 Shepardtown, WV Steve Parker 25443 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Riverdale Crematory 10/14/0 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Shead Mortuary Service, P.A. 1409 Fairlakes PL Ste B Mitchellville.Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 2 🖸 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

Physician: The law requires that the death certificate be executed certificate After this death.

or Attending

25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

neral Director: After this certificate has been sign filled in by the funeral director, page 2 should be 24 hours after deat Funeral Director: Hospital

completely To the within 2 8 1

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Anbust

OCT 13

5 Pending

investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Anna now Rd # 305 Glenn 37 Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28a. Date of Injury (Month, Day, Year)

and manner stated.

FARMAD JAMALI, MD Glenn Dale

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

100 58213

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	aryland / De	partment of H ertificate of L	lealth and Death	Mental Hy	giene Reg. No. 200	9 34235
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yo	3. Time of Death
4	/Medic Examin		Verona Josephin  4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	October	9 200 4c. County of	
-			Laurelwood Nursing	Home		E1kton				cil
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$	7. Ag M 2 <b>X∑X</b> F	ge (In yrs. last birthda 7.6 Yrs	Months   Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	Birthplace (State or Foreign Country)  orth Carolina
	D		Usual Residence of Decedent		76			Dec. 13	1932 N	JE CHI CHI CITING
	I within 72 hours after death with the Maryland jlene. I than "natural", or items 23a or 28a-f show The Medical Evenine must be neithed at	o	10a. State 10b. County		10 <i>c</i> . City, Town or					10d. Inside City Limits 1 ☐ Yes 2√√No
	r 28a-1	Directo	Maryland   Cecil  10e. Street and Number	-	Elkt	on 10f. Zip Code			10g. Citizen of Wha	
	23a o ust be		386 Tonys Road			2192	1		United	States
	er dea items	Funeral	The manual dialege	2. Was Decedent Armed Forces?	Ever in U.S. 1	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	ispanic Origin? (s n, Mexican, Puel	Specify Yes or No- rto Rican, etc.)	14. Race - Black, \	American Indian, White, etc.
036	urs aft al", or Eveni	by	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	1 □Yes 2 🟋 If Yes, Give Year or Dates:	NO .	1 □ Yes 2 😿 No	Specify:		Specify:	White
1215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. De	cedent's Usual Occupa ve kind of work done of b. DO NOT use retired	ation Juring most of we	orking	16b. Kind of Busin	ess/Industry
121	within ene. than '	ldmc	Elementary/Secondary (0-12)	College (1-4or	5+)					
ב ב	al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)		Sewi	ng Machine			Manufaci Maiden Surname)	uring
ylai	ould be Menta arked	To E	Orville Miller				Ida Gr	een		
Maryland 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, I've Meconce.	1 8	19a. Informant's Name/Relationship (Type Jane Campbell / Da	•	11	illing Address (Street a			-	
ē,	s 1 an if Heal item 2 other		20a. Method of Disposition	agneer		sposition (Name of rematory or other place		Date	20c. Location - Cit	
Ē	Page: nent o ant: If ury or		1 Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Church	of Christ	<b>Υ^₹7</b> :		Elkton, N	Marvland
Baltimore,	ermit. Departi nporti ny inj		21. Signaturu i Funcial Survice License			22. Name and Addres	ss of Facility C	crouch Fu	neral Hon	ne
	40 = 6 Q	4 N	23a. Part 1. Enter the disease, or complic	ations that caused						Maryland21901
ų, į	Physician	ē U	shock, or heart failure. List only one Immediate Cause (Final	cause on each li	5746E		g, odori do odraio	ab or roophatory an	1001,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence of):	CUETS				unknown
ľ	Examiner	_	Sequentially list conditions, b.	- D						
	uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	Due to (or as	a consequence of):					
oʻ	an and		that initiated events c. resulting in death) Last	Due to (or as	a consequence of):					
8/60	certificate be executed rding physician and ise as the burial-transit	dical	d.							
Ď X	certifi Iding I	/Mec	IF FEMALE:	c. If yes, outcome	of pregnancy				001 Peter	A delicera
. BOX	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 □ E <i>c</i> topi <i>c</i> pregnancy 5 □ Other (s <i>pecify</i> )	/		23d. Date of Month	
7. O	law requires that the death certificates been signed by the attending 2 should be detached for use as	Physician/Me	9 Unknown	9 ☐ Unknown						
S.	ires th signec	ρ	Part II. Other significant conditions cont	•	· ·					ite to the cause of death?  ☐ Probably 4☐-Unknown
ecords,	w requ	Completed	Disposes -					24a, Was		re autopsy findings available
E E	a ∺ ⊲ I	omp	DEMOND					autop perfoi	sy pric rmed? dea	r to completion of cause of
Ма	ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of De	1 □ Yes eath (Check only o	- 1	JYes 2 LINO
5	Physion this call direct		1 ☐ Yes 2 ☐ No Ho  27. Manner of Death	spital: 1 ☐ Inpati 28a. Date of Inju	ent 2 ER/Outpa		4 Nursing	_	lence 6 Other	(Specify)
0	th. : After funer	ertification: To	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ary, Year) 260. Tille	y Work	yat (? Yes 2.≝No	28d, Describe r	now injury occurred	
VISION	r Atter	tifica	3 ☐ Suicide 6 ☐ Could of be 4 ☐ Homicide determined	28e. Place of Inj	jury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
5	ital or Insaft ral Dii lled in	O								
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  Check only 2 edica xamin	cian: To the best er: On the basis o and manner st	of examination and/o	eath occurred at the tin rinvestigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (/	
			/t/lon			D540			120070	
	11		30. Name and Wress of person who con	pleted cause of c	death (Item 23a) (Typ	e, Print)	C. 1.	Inc. A	(Lande 1	15713
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	1-11	JUTE	(0)	ا عادی	, , , , , ,
	Registra	ar	OCT 13	2009	neva B.	parl				

09-07810 Eugene Proctor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ogene Proctor		- For State	Ce	rtificate of De		wichtarriyg	Reg.	No. 200	9 3423
Physicia	_	Registrar 1. Decedent's Name (First, Middle,La	st)			1	Date of Death	)av Year	3. Time of Death 0633 hrs
ledical Exami			OCTOR	145.0	ity, Town, or Loc		October 8, 2	2009 4c. County of Death	
		4a. Facility Name (if not institution, gir PG Hospital Center	ve street and number)		neverly	cation of Death		Prince George	
Funeral	7	5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday) If	Under 1 Year	If Under 24Hrs.	3. Date of Birth	MM/DD/YYYY) 9. Birt	hplace (State or
Director		579-38-1427 Usual Residence of Decedent	M 2 F	78 Yrs. M	onths Days	Hours Min.	9/11/19	Pareig Cou	<sup>Intry)</sup> Maryland
any	f	10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits
ɗaryland 28a-f show any 1 at once.	ctor	DC		Washingt	on				1 X Yes 2 No
Maryl 7 28a-1	Direct	10e. Street and Number		101	. Zip Code		10g	. Citizen of What Cour	ntry?
ith the Maryland 23a or 28a-f shov		5010 Southern A	Ave. SE # 12	12 Mar De	20019	nic Origin? ( Spec		Nited State	e.s can Indian, Black,
death w or items must be	Funeral	1 Never Married 2 X Marrie	d Armed Forces?			Mexican, Puerto Ric		White, etc.	
ifter de	by Ft	3 Widowed 4 Divorce	1 Yes 2 X No	1 Yes	2 X No s	specify:		Specify: Blad	ck
hours afternatural", Examiner		15. Decedent's Education (Specify of		16a. Decedent's U	sual Occupation f working life. Do	n (Give kind of world O NOT use retired		16b. Kind of Business/	industry
36 thin 72 l than ", edical F	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Chama II	1		,	0 0 0	t C-11-
5-0036 led within 72 Hygiene. other than '	틍	12 17. Father's Name (First, Middle, Las	t) Unknown	Stern Wa	18.	.Mother's Name (F	irst, Middle, Ma	eiden Surname) Unl	ty Schools known
21215-0036  Juld be filed within 7  Mental Hygiene.  marked other than c event, the Medica	Be (								
	1	19a. Informant's Name/Relationship (						er, City or Town, State	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.	213	Kevin Proctor / 20a. Method of Disposition	Son20b	Place of Disposition	(Name of cemet		dorf, N	<u>fary land 20</u> 20c. Location - City or	0601 Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		1 X Burial 2 Cremation 3	-	crematory or other p		10/10	10000		
ltin nit. Pa artmer sortan rry or	1	4 Donation 5 Other Specification of Funeral Service Lice		eorge Wash 22. Name	ington and Address of	f Facility Pope	72009 1	Adelphi. M al Homes, l	Maryland
III Dep W	- 1	spauger	<i>p</i>	<b>1</b> 5538	Marlhor	o Pike F	orestwi	ille. Marv	and 20747
Physician /Medical		23a. Pirt I. Enter the disease, or comfailure. List only one cause on e	each line.				espiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
kaminer	<i>0.0</i>	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		scular Disea	ase			Deatin
,			Due to (or as a consequence						
	iner	if any, leading to immediate	Due to (or as a consequence	of):					
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):		·			
760, ficate be executed g physician and the burial - transit	Medical	UNPENDED	AMENDED			<del></del>			
760, icate bo physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre			ī <b>-</b>		23d. Date of deliver	
Box 687  e death certific  the attending p	cian	past 12 months?	1 Live birth 4 Pregnant at time of o	2 Fetal dieath 5 Other	(Specify)	Ectopic pregnand	зу	Month	Day Year
O. Box 687 at the death certific d by the attending p	Physician/	1 Yes 2 No 9 Unknow	9 OHKHOWH					pacco use contribute to	the course of death?
i, P.O.	by P	Part II. Other significant conditions Head Injury	s contributing to death but not	resulting in the unde	rlying cause give	en in Part I.	1 Yes		bably 4 V Unknown
ords, I w requires s been sig should be	ted	rieau irijury			<del></del>		24a. Was a		utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	Completed		<u> </u>	<del></del>			autops	ned? death?	completion of cause of
tal Rec		25. Was case referred to medical	r		26.Place o	of Death (Check or	1 Yes 2	No 1 🗸 Y	es 2 No
Vital   hysician: this certif	o Be	examiner?	Hospital: 1 Inpatient 2	✓ ER/Outpatient 3	DOA O	other Nursing	Home 5 F	Residence 6 Oth	er:
vision of or Attending Pheter death.  Director: After to in by the funeral	ī.	27. Manner of Death  1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injur FOUND:		S	28d. Describe h Subject fell	ow injury occurred	
ivisior or Attend after death Director:	catic	2 Accident 5 Pending Investigation	0-40 0000	0545 hrs		es 2 V No	28f Location (S	treet and Number or R	tural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.		29a. Certifier 1 Certifying Phys	ician: To the best of my knowle er:On the basis of examination	edge, death occurred	at the time, date	e and place, and d	lue to the cause the time, date a	e(s) and manner as sta	ated. the cause(s)
To d withi To th	Medical	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed (M	
		Daniel Am.	the 11 min		O.C.M	1.E.		October 8, 2009	9
		30. Name and address of person wh							
R 4		Pamela E. Southall, MD	Assistant Medical Ex		Penn Street,	Baltimore, MI	D 21201		
S Regis	tate	31. Date filed (Month, Day Year) OCT 1 3 2009	32: Registra s Signa	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:00 A M October 8 2009 ar Sylvia Robin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Care and Rehabilatation Crofton Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Davs Hours Min 0/7/2011918 Director 578-05-1491 Usual Residence of Decedent show 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f MD Anne Arundel Crofton 1 Yes 2 No krd 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral with United States 2131 Davidsonville Road 21114 items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Dry Cleaning Co-Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Melomet Benjamin Lucks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis R. Robin-Son 2131 Defense Highway Crofton, MD 21114 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🖺 Removal from State 4 Donation 5 Other (Specify) King David Mem Gdns ! 10/11/2009 Falls Church, VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike
Rockville, MD 20852 21. Signature of Funeral Service Licensee Chapels Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Enysician MONIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ģ Pregnant at time of death 5 Other (specify) Month Dav Year the 9 Unknown a | I Inknow been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Rakesh Arora, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

14300 Gallent Fox Lane, #222 Bowie, MD 20715

State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 11:15 a<sub>M</sub> **07** 2009 Olivia Rizo Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Wheaton Montgomery Wheaton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. April 16, Year 1910 Colombia Director 212-94-1984 99 Usual Residence of Decedent 28a-f show 10a. State 10b, County with the Maryland 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Wheaton 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 11901 Georgia Avenue 20902 United States items ? 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. P 1 Never Married 2 Married þ 1 X Yes 2 □ No Specify: Colombian Maryland 21215-0036 If Yes, Give Year or Dates and Mental Hygiene.
is marked other than "natural", Specify: Caucasian 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1.2 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lucino Rizo Guada1upe Vanegas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau once. Sandra E. VanBochove, granddaughter 9808 Old Spring Road, Kensington, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Parklawn Memorial Park 4 Dopation 5 DOther (Specify) 10/12/2009 Rockville, Maryland 21. Signarure o Fune Servi 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M00709 Inc. 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ASCITES Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ō Month Day Year Pregnant at time of death detached Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy performed' death? Yes 2 K No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🗷 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 X Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certig 29d. Date signed (Month, Day, Year) D58962 October 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Shashank G. Patel, M.D., 18121 Georgia Avenue, Suite #103 Olney, Maryland 31. Date filed (Month, Day, Year) State 3 2009 OCT Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dorothy L. 2009 Remp October 3:25 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 19012 Dowden Circle Montgomery Poolesville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 578-30-9116 81 1/8/1928 Marvland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examination must be invitined at Maryland Montgomery Poolesville Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19012 Dowden Circle 20837 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. ≥ White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Homemaker</u> Private 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Helen Grav Calvin H. Wolfe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Remp - Husband 19012 Dowden Circle, Poolesville, MD 20837 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or one 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. 10/12/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. UPPER Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner 5786911 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the tuneral director, page 2 should be detached for use as the burnal-transit resulting in death) Last Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mop Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 2 No 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 5 1 Tes 2 No 3 Probably 4 Unknown Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 1 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, zuneon Wy 000099 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hector Asuncion 18730 liberty Mill Road Germantown, MD 20874 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

**Physician** /Medical Examiner

**Funeral** Director

ed other than "natural", or items 23a or 28a-f show event, the Modical Experimentative routified at

Health and Montal Hygiene. is marked other pe Pages 1 and 2 should per it. Pages 1 and 2 s
Detartment of Health at
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

SOFR

**Physician** /Medical Examiner

burial-tra attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. the filled in by соmpletely das

4a. Facility Name (If not institution, give street and Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON ANNE ARUNDEZ PRN EXTER Birthplace (State or Foreign Country)
 NY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/29/1932 7. Age (In yrs. last birthday) f Under 1 Year 5. Social Security Number Days 1 □ M 2 → F 76 132-26-2647 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Crofton 1 □ Yes ZYNo Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 USA Funeral 1616 Angus Ct. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2√√√No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: ş 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norma Ogden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD 21114 Victoria Herosian \_Daughter <u> 1616 Angus Ct.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buria! 2 Cremation 3 ☐ Removal from State 10/5/2009 Glen Burnie, MD Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PHEUMONITIS 2 Aours disease or condition resulting in death) o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Year Month Day ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown ACUTE REVAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 □ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Kinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mc conditions see aimples , Mo DOOCSTIA PCTOBER 3,2009

DHMH 17 Rev 1/2001

State

Registrar

301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Signature

CUILLERMO JOSE GIBNERECO

nct 06

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	or ivial yland / De	Certificate of D		Reg. N	7005	34241
	Physici	ian	1. Decedent's Name (First, Middle, Last)	CD		2	Date of Death Month 10/2/	Payooo Year	3. Time of Death
	/Medi		Robert Edwin Richards,  4a. Facility Name (If not institution, give street and no		4b. City, Town, or L	ocation of Death		c. County of Death	0219 M
لمها	Examin	iei	Anne Arundel Medical Cer	*		napolis		Anne Aru	
	Funeral Director		5. Social Security Number 023-20-0338 6. Sex 152M 2□F	7. Age (In yrs. last birthe	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea 3/15/192	9. Birth	place (State or Foreign ntry) MA
	fand ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location			1	10d. Inside City Limits
	e Mary a-f sh inied	ctor	MD Anne Arundel	Fr	iendship				1 ☐Yes 🍇 📉 No
	eath with the Marylans S 23a or 28a-f show	Funeral Director	10e. Street and Number	•	10f. Zip Code		10g. (	Citizen of What Cou	ntry?
	eath v	eral	6783 Wilson RD.  11. Marital Status 12. Was Dec	edent Ever in U.S.	2075		fv Yes or No-	USA 14. Race - Americ	can Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.	þ	Armed F	2 No 44-	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2★□No	, Mexican, Puerto Ric Specify:	can, etc.)	Black, White,	
15-(	n 72 h	olete	15. Decedent's Education (Specify only highest grade completed)	16a. D	lecedent's Usual Occupat Give kind of work done du ife. DO NOT use retired)	tion Iring most of working	16b.	Kind of Business/In	dustry
212	d withi giene.	Completed	Elementary/Secondary (0-12) College	1-40r 5+)	Engineer			estinghou	se
pu	be file ntal Hy od othe event,	Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Name (F		en Surname)	
ryla	thould and Mer marke	ပ္	Joseph Edmond Richards  19a. Informant's Name/Relationship (Type. Print)	19h M	Mailing Address (Street ar	Irene Ca		var Tawn State 7in	2 Codo)
Ma,	alth ar 27 Is				3 Wilson Rd		lship, MD		Codey
Baltimore,	ges 1 a t of He If item or othe		20a. Method of Disposition  ★★Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of D cemetery,	isposition (Name of crematory or other place)	Date	e 20c.	Location - City or To	own, State
tim	it. Pag rtment rtant: njury o		4 ☐ Donation 5 ☐ Other (Specify)	Lakemon	t Memorial	10/6/2		avidsonvi	
Ba	Depar Impo		21. Signature of Funeral Service Licensee		22. Name and Address 12 Ridgely		•		
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not					Approximate Interval Between
-	Physician	ê j	Immediate Cause (Final disease or condition	Peritoniti.	2				Onset and Death
-	/Medical Examiner		resulting in death)  Due to	(or as a consequence of):	:				
	B +	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	(or as a consequence of):	:				
	ecute and transi	Examiner	that initiated events	(or as a consequence of)					
68760,	rtificate be executed ng physician and as the burial-transit		5 July 10	(or as a consequence or).	•				
.89	rtificat ng phy as the	Medical	U						
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burns after doesth.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/	in the past 12 months?	tcome of pregnancy birth 2 ☐ Fetal death gnant at time of death nown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
S, P.	ss that gned b	by Pł	Part II. Other significant conditions contributing to c	leath but not resulting in th	ne underlying cause given	in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ord	require	ted					1 ☐ Yes	2 No 3 Prol	oably 4 ☐ Unknown
of Vital Records,	n: The law ficate has b	Completed					24a. Was an autopsy performed? 1 □Yes 2 🔼 N	prior to co death?	ppsy findings available mpletion of cause of
Ξ	yslcla is certi directc	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 →	√npatient 2 ER/Outpa		26. Place of Death (0		6 ☐ Other (Special	6/)
n o	ing Ph		27. Manner of Death  1 Natural  1 Pending  28a. Date (Mor	of Injury 28b. Tim	ne of 28c. Injury a		d. Describe how inj		<i>y</i> /
Division	death.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place	of Injury - At home, farm		es 2 No	Location (Street	and Number or Rure	al Pouto Number
Div	al or A s after I Direct	ertii	4 Homicide determined build	ing, etc. (Specify)	, street, ractory, office	201	City or Town, Sta		ar moute Number,
	he Hospit in 24 hour he Funera pletely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the land man	e best of my knowledge, on casis of examination and/oner stated.	leath occurred at the time or investigation, in my opi	e, date and place, an nion, death occurred	d due to the cause at the time, date a	(s) and manner as s and place, and due to	stated. o the cause(s)
	Nith To To To To To To To To To To To To To		29b. Signature and title of certifier  NounBuch M	9	29c. License	1		Date signed (Month,	
	KUA 10+1		30. Name and address of person who completed causes of Peut, 100 31. Date filed (Month, Day, Year) 32. F	se of death (Item 23a) (Ty Looi Weshick	pe. Print) and an	napolis, t	40		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	park				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 8, Day 2009 Year Charles Major Stover 2:57 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney 8. Date of Birth (Month, Day If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 79 226-26-8031 1929 Virginia October 12, Director Usual Residence of Decedent 10c. City, Town or Location Rockville show 10a. State 10b. County 10d. Inside City Limits Montgomery Maryland Director 1 Yes 2 No 28a-f Item 27 is marked other than "natural", or items 23a or 28a-6 other traumatic event, the Medical Executives must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 USA 12806 Weiss Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 46-49 1 ☐ Yes 2 X No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Architecture 12 Architect 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Margaret Major Charles Otto Stover ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12806 Weiss Street, Rockville, MD 20853 Grace Ann Stover / Wife 20b. Place of Disposition (Name of care of Heaven)
Cate of Heaven
Cemetery 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any Injury or ot 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P. O. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> sign be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Atter t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin.
within 24 hours after death.
To the Funeral Director: Att
completely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 🗡 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) StI na MD person who completed cause of death (Item 23a) (Type, Print)
Paspula, MD 18404 Oxfordshire Terrace, Olney, MD 20832 Aruna K. Paspula, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

OCT

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certifi	cate of Death		Reg. N	200	19 3421
Physician/ edical Examine	1. Decedent's Name (First, Middle,Last	)			2. Date of Death Month Da October 9, 20	y Year 109	3. Time of Death 2156 hrs
	4a. Facility Name (if not institution, give Suburban Hospital	street and number)	4b. City, Town, o Bethesda	Location of Death		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 6. Se 579-70-4499	7. Age (In yrs. last b	irthday) If Under 1 Yes Months Day		_ `	1938 Forei	
er death with the Maryland , or items 23a or 28a-f show any must be notified at once. Funeral Director		Drive  12. Was Decedent Ever in U.S. Armed Forces?	Bethesda  10f. Zip Code  2081  13. Was Decedent of H If Yes, specify Cuba	spanic Origin? ( Sp	U pecify Yes or No-	Citizen of What Cou SA 14. Race - Amer White, etc.	10d. Inside City Limits  1 Yes 2 No ntry?
36 in 72 hours afte nan "natural", iteal Examiner pleted by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes 2 X No. a. Decedent's Usual Occupe during most of working life  Microbi	ation (Give kind of ver. DO NOT use reti	red)		
Should be filed within and Mental Hygiene. 7 is marked other thatie event, the Med	Hilario Soares			San	e (First, Middle, Maid tana Extr	os	7-0-10
re, MD 21 Land 2 should I Health and Mer fritem 27 is mar r traumatic eve	19a. Informant's Name/Relationship (T Nirmolini Soares	/Wife	19b. Mailing Address (Stre 9801 Sir e of Disposition (Name of or	gleton D	rive, Bet		20817
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 XBurial 2 Cremation 3 4 Donation 5 Other Specify: 21. Synnoure of Funery Service Len	Removal from State Gate Ceme	natory or other place) Of Heaven etery	0c 2	t. 13,	Silver Sp	oring, MD
Physician /Medical	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	ications that caused the death. Do		rsity Bl	vd. W., S	ilver Spr	ing, MD 20 Approximate Interv. Between Onset an
xaminer E E E	or condition resulting in death)  Sequentially list conditions.	Head Injury  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Death
760, cate be execuiphysician and the burial - tra	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	AMENDED  28bperMF 10-1  23c. yes, outcome of pregnand Live birth  4 Pregnant at time of death  9 Unknown	5 - 09 RMW M cy 2 Fetal death 3 5 Other (Specify)	Ectopic pregna	ancy	23d. Date of delive Month	ry Day Year
Records, P.O. Box 68:  The law requires that the death certifit ficate has been signed by the attending page 2 should be detached for use as Completed by Physician	Hypertensive Atheroscler	contributing to death but not resul otic Cardiovascular Diseas	-	given in Part I.	1 Yes 2	2 No 3 Pro	to the cause of death?  babbly 4 Unknown  utopsy findings availab  completion of cause of
tal Recoitant: The la certificate ha ector, page 2	25. Was case referred to medical		26.Pla	ce of Death (Check	only one)		/es 2 No
of Vital ng Physician: offer this certiseneral director 1: To Be	1 Yes 2 No		b. Time of Injury 28c. In	Other <sub>4</sub> Nursi	28d. Describe how		er:
vision or Attendinuter death. Director: A in by the furification	1 Natural 5 Pending 2 V Accident Investigati 3 Suicide 6 Could not determine	Oct 9, 2009 28e. Place of Injury - At home	215 hrs , farm, street, factory, office	Yes 2 No building, etc.	or Town, State	et and Number or F	Rural Route Number, Cit
hin 2		an: To the best of my knowledge, On the basis of examination and/o	death occurred at the time,	date and place, and	9801 Singleton E d due to the cause(s at the time, date and	) and manner as sta	ated.
Med Company	29b. Signature and title of certifier	and manner stated.	29c. Licer	se number	2	9d. Date signed (M October 10, 20	lonth, Day, Year)
	1	completed cause of death (Item 23a Chief Medical Examiner	a) 111 Penn Street, Ba	altimore, MD 2	1201		
State Registra	31. Date filed (Month, Day, Year)  OCT 13 200	3. Registrar's Signature	parked				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9, 2009 Year **Physician** 2:40 AMM October Monique Anne Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House - Montgomery Hospice Derwood 8. Date of Birth (Month, Day, Year) 12/05/1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days 1 □ M 2 🖾 F 80 France 129-26-0540 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐Yes 2 X No Directo Maryland Montgomery Montgomery Village 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Pages 1 and 2 should be filed within 72 hours after death with 23a 20129 20886 United States Waringwood Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Bridge Emile Roman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20129 Waringwood Way Montgomery Village, MD. 20886 David S.J. Smith (Spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 9 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licens 10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Intracraníal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☒ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**X** No 2 No 1 □Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2x No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours arter committee To the Funeral Director: Aff investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

9 10

P.O.

State Registrar

Medical (

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) OCT 13 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kouartchou

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

163748

29d. Date signed (Month, Day, Year)

October 9, 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 8 Day 2009 ear 10:02 P. M Mary Ann Smith 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July25,1923 Birthplace (State or Foreign Country) Social Security Number 180-12-3827 7. Age (In yrs. last birthday, 1 □ M 2X F Months Days Hours Min. Pennsylvania Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Silver Spring 1 □ Yes 2 No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20904 United States 3122 Gracefield Road, #318 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married

1 ☐ Yes 2 📉 No

16a. Decedent's Usual Occupation

Secretary

20b. Place of Disposition (Name of cemetery, crematory or other place)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

White

16b. Kind of Business/Industry

20c. Location - City or Town, State

**RCA** 

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Wilson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Boucher Avenue Annapolis, Maryland 21403

Metropolitan Crematory 10/10/2009 Alexandria, Virginia

Physician /Medical

Physician

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

and Mental Hygiene.

: If item 27 i

permit. Page Department of Important: If any injury or

Pages 1 and 2 should be nent of Health and Mental

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a State

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17 Father's Name (First, Middle, Last,

Herbert Winward

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

Debra Ann Smith -daughter

1 ☐ Burial 2 XCremation 3 ☐ Removal from State

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Director

Funeral

2

Completed

Be

ပ

Examiner law requires that the death certificate be executed

and burial-tra attending physician the as for use the signed by t has page 2 certificate this After 1

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The death. after death Director: filled in by To the Hospital of within 24 hours at To the Funeral D npletely 20

21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA Donal 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Coronary Artery Disease Sequentially list conditions Examine Due to (or as a consequence of) any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of) Physician/Medical Atrial Fibrillation IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes: Hypothyroid: Breast Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 XNo 2 XNo 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo Certification: To 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature 3

DHMH 17 Rev 1/2001

State

Registrar

	For State Registrar				-	rtificate of	Health and N Death	R	eg. No. <b>2</b>	009	
in al	1. Decedent's Nan Nadine	ne (First, Middle	, Last)		S	ilman		2. Date of Dear Month October		2009 <sup>Year</sup>	3. Time of Death 7:30 A
er	4a. Facility Name		_				or Location of Death			ounty of Death	
			d Apt.		- 1 1 (- 11 - 1 - 1	Bethes		O Date of Birth		gomery	
	5. Social Security   466-46-5	842	6. Sex 1 □ M 2 🔼 F		s. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day 12–15–19	Year)	_Cot	nplace (State or Forei untry) XAS
	Usual Residence of	of Decedent 10b. County		10c. (	City, Town or Lo	cation					10d. Inside City Limit
ō	MD	Montgo	mery	Ве	thesda						1X⊑Yes 2 □ N
Director	10e. Street and Nu	ımber				10f. Zip Code		1	0g. Citizer	n of What Cou	untry?
	5101 Ri	ver Roa	d Apt. 1	710		20816			Unit	ed Sta	tes
by Funeral	11. Marital Status  1  Never Mar  3  Widowed	ried 2 <b>X</b> Marri	Armed	ecedent Ever in Forces? s 2 \ No Give Dates:		Was Decedent of I If Yes, specify Cub 1 □Yes 2☑ No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: Whi	, etc.
1			t grade completed	-	ı (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king	16b. Kind	of Business/l	ndustry
combiered	Elementary/Sec	ondary (0-12)		(1-4or 5+)		mic Advi	,	Ŧ	orei	en Gov	ernment
טע	17. Father's Name	(First, Middle,					18. Mother's Nam				
5	George S	alem					Samia	Salman			
	19a. Informant's N	lame/Relationsh	nip (Type. Print)		19b. Maili	ng Address (Street	t and Number or Ru	ral Route Numbe	r, City or To	own, State, Z	ip Code)
			Jr. / Sp				ad #1710				
			3 ☐ Removal from	m State	cemetery, crei	esition (Name of matory or other pla Cremator	ice)			tion - City or 1 Churc	
	21. Signature of F						ess of Facility Jos	I .			-
	<b>→</b> W.L.	serves 1	Bu	NAIN-	5	130 Wisc	onsin Ave	- NW Was	hinot	ton. Do	20016
	23a. Part 1. Enter	the disk se, or	complications tha	a ed the de			ing, such as cardiac				Approximate Interval Between
	Immediate Cause	(Final			notic C	tundromo				1	Onset and Death
	resulting in death)		aDue t	to (or as a cons	equence of):	Syndrome					
	Sequentially list of	onditions.	b								
	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	nmediate erlying r injury	Due t	to (or as a conse	equence of):						
Examine	that initiated event resulting in death)	S	c	o (or as a conse	equence of):						
			a.	(							
5	<u> </u>		d								
in y sicial princated	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknow	months?	1 🔲 Liv	outcome of preg re birth 2  Fe egnant at time o known	tal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		230	d. Date of deli Month	very Day Year
	Part II. Other sign		ns contributing to	death but not re	esulting in the u	nderlying cause di	ven in Part I	23e Did to	hacco use	contribute to	the cause of death?
a by	. are in ward origin		no commodanty to	dodin but not n	oditing in the d	ndonying dadde gi	verifit are i.				obably 4₺ Unkno
nublered						5		24a. Was a	n [	24h Were au	topsy findings availa
1								autops perfori	ned?	prior to c death?	ompletion of cause
ע	25. Was case refe	rred to medical					26. Place of Dear	1 ☐ Yes		1 ∐ Yes	2 ∐No
1	examiner? 1 ☐ Yes 2 🛱	] No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	her:	ome 5 Reside		Other (Spec	cifv)
	27. Manner of Dea 1 ☑ Natural	th 5 Pending		te of Injury onth, Day, Year)	28b. Time o	f 28c. Inju		28d. Describe ho			,)
	2 Accident	investig	ation				]Yes 2 □ No	*			
	3 ☐ Suicide 4 ☐ Homicide	6	28e. Pla	ce of Injury - At Iding, etc. <i>(Sp</i> e	home, farm, str cify)	eet, factory, office		28f. Location (S: City or Town		lumber or Ru	ral Route Number,
				he best of my k	nowledge, deat	h occurred at the t	ime, date and place	, and due to the o	ause(s) ar	nd manner as	stated.
cei IIIIcalioni,	29a. Certifier	1X Certifyin	g Physician: To t		nation and/or in	vestigation, in my	opinion, death occu	rred at the time, d	ate and pl	ace, and due	to the cause(s)
cei IIIIcalioni,		1X Certifyin 2 ☐ Medical I	xaminer: On the	e basis of exami anner stated.							
Cerundanon	29a. Certifier (Check only	2□ Medical I	xaminer: On the	e basis of exami anner stated.		29c. Licens D2330		2		signed (Month 9/2009	n, Day, Year)
Certification:	29a. Certifier (Check only one)  29b. Signature and 30. Name and add	d title of certifier	Mylwo who completed ca	anner stated.	em 23a) (Type,	D2330	8		10/0	-	n, Day, Year)
Medical Certification: To	29a. Certifier (Check only one)  29b. Signature and 30. Name and add	atitle of certifier  The sess of person of M. Prie	Ny Market Completed ca	anner stated.	em 23a) (Type, :ledge I	D2330 Print) Dr. #4100			10/0	-	o, Day, Year)

			For State Registr <i>a</i> r	State of M	aryland / Dep <i>Ce</i>	ertificate of I		nd Mental H	ygiene Reg. No	2009	34247
	Dharis		1. Decedent's Name (First, Middle, La	ast)				2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		MARION M.	SAVAGE				OCT.	10	2009	21:59 M
٠,	Examir	ner	4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, or	Location of	Death	4c.	County of Death	
			Prince Georges Ho		- (	Chever1	y If Under 24	1 Hro T o Data at D		ince Geo	
п	Funeral Director			Sex 7. Ag 1 ☐ M 2 🛣 F	ge (In yrs. last birthda) Yrs.	Months Days	Hours	Min. 8. Date of B (Month, E Nov 2	Day, Year)	Cour	
			Usual Residence of Decedent		00			NOV Z	/, 15	20 Va	•
	yland		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Ba-f s	cto	MD Prince (	Georges	Largo						1 □ Yes 2 🔀 No
	ill the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cour	itry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, if a Medical Examinat must be notified at		9815 Lakepointe (			20774				SA	
	item item	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	10- 1	<ol> <li>Race - Americ Black, White, 6</li> </ol>	
21215-0036	irs aff	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 [X] If Yes, Give Year or Dates:	140	1 ☐ Yes 2 🔼 No	Specify:			Specify: Bla	ıck
ğ	2 hou	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	ation		16b. Kir	nd of Business/Inc	dustry
215	thin 7 e. an "n	nple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	life	e kind of work done of DO NOT use retired	during most o il)	of working	10		
21	filed wil Hygien ther th	Completed by		3 yrs.	LF	N				sler ins	stitute
Ē	~ = 0 %	Be	17. Father's Name (First, Middle, Last	,				s Name (First, Middl		Surname)	
<u>X</u>	should be tand Mental s marked o	은	Clarence Marshall					eth Smith			
<u>a</u>	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship	,	l	ling Address (Street					
á,	1 and Heal Heal Hem 2		Robin Savage-Daug	ghter		Lakepoin  position (Name of ematory or other place		#301 La Date	<del>,</del>	Md . 2077 cation - City or To	
ᅙ	ages ent of it; if ii		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			ematory`or other plac d Memorial		0 21 2000		•	,
Baltimore, Maryland	artm ortar injur		21. Signature Funeral Service Lice			22. Name and Address IATS NATI			·	ilworth,	117.
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic enonce.		Mitasue	Calore		308 Suitl	and Rd	ai nome o L. Suitla	nd, M	yrand Id. 20746	
1	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any leading to immediate Cause. Enter Underlying	a. Acute R Due to (or as	enal Failu a consequence of): ic Acidosi	re	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
ລ໌	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		s uncontro a consequence of):	11ed	··- <u>-</u>				
	ificate be g physicia ss the bu	edical		d. Pulmona	ry Embolis	sm					
C. Box	t the death certific by the attending p ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify)	у		2	3d. Date of delive	ery Day Year
Records, F	w requires that the desired by the should be detached	þ	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause give	en in Part I.		tobacco us		ne cause of death?
င္ပ	e law requ has been e 2 shoult	Completed				-w <u>-</u>		24a, Wa	s an	24h Were auto	nev findings available
ž		шc						auto	opsy formed?	death?	psy findings available mpletion of cause of
	ilcian: Th certificate rector, pag	a l	25. Was case referred to medical				26. Place o	1 ☐ Yes of Death (Check only		1 ☐ Yes	2LINo
	Physician: this certific	o B	examiner? 1 ∐ Yes 2 ဩNo	Hospital:	ent 2 ER/Outpatio	ent 3 DOA Othe	nr:	sing Home 5 🗆 Res		Other (Specif	v)
		ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ırv 28b. Time			28d. Describe			· · · · · · · · · · · · · · · · · · ·
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inj	ury - At home, farm, s c. <i>(Specify)</i>	M 1□	Yes 2 □No	28f. Location	(Street and own, State)	d Number or Rura	I Route Number,
	ie Hospit n 24 hour ie Funera	Medical (	29a. Certifier  (Check only one)  1   Certifying Pt 2   Medical Example   Medical Ex	nysician: To the best miner: On the basis o and manner sta	f examination and/or	ath occurred at the tir investigation, in my o	me, date and pinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as s place, and due to	stated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License				e signed (Month,	
			Hoom	e, m	<b>S</b>	Do	00 68	1294	/ (	1/12/	09
12	-4	•	30. Name and address of person who			Print)	TWF	3001 Hos	pital	Dr. Che	20785 everly,MD
Ė	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	COPHILU ar's Signature						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2009 Oct. 11 1:15 A M Ronald J. Smith, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Laurelwood Care Center Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 73 Yrs. Director 185-28-6717 June 3, 1936 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 1 ☐Yes 2 No Director Maryland Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21911 121 Stevens Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Packaging Technical Rep 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Zajano Edward Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Stevens Rd., Rising Sun, MD 21911 Shirley A. Smith/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-15-2009 | Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 22 Name and Address of Facility R.T. Foard Funeral Home, P.A. Signature of Funeral Service Licensee 21911 111 S. Queen St., Rising Sun, MD Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final U **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ULOSEPSIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit COAGULOPATH Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ has been sig te 2 should b Deneutra 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate ha 1 ☐ Yes 2 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 13 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by e Funeral Direc 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca completely her: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exam within 2 To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ifier 12 007 09 054073 DU ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Suite lot Alun STONE NEWSEK 31. Date filed (Month, Day, Year) CENTURIAN DI , M SHE 32. Registrar's Signature State Registrar

**Physician** /Medical

**Examiner** 

Prince George's 9511 Sheridan Street Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 10/21/1942 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months Hours Min. 214-42-3404 Washington, D.C. **Director** 66 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits show 10a. State any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director 28a-f Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 9511 Sheridan Street 20706 U.S.A. or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XXIo White Be Completed by Specify 3 Widowed 4 Divorced natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Nicholas Graner Thelma Madeline Ireland ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9511 Sheridan Street Robert R. Smith-Husband Lanham, MD 20706 permit. Pages 1 and Department of He Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 10/8/2009 Clinton, Maryland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the attease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): attending physician To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) manner stated. Medical (Check only one) Signature and title of celtifier Name and address of person who completed cause of death (Item 23a) (Type MAIM 441 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

4c. County of Death

AMEND#19b per FH State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar AACO HEALTH DEPT. 10/9/09 CMH

4a. Facility Name (If not institution, give street and number)

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

34250

Physicia /Medica Examine	•
Funeral	

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a "Modical Evantina must be notified at appear.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

2 Sta Registrar

	1 - State Registrar	Registrar Certificate of Death								Reg. No.					
	1. Decedent's Name	e (First, Midd	lle, Last)				Date of Death			3. Time of Death					
an	LOUISE			OCTOBE		ay • 20	Ye ar	12:45A M							
cal ner	4a. Facility Name (/		4b. City, Town, o	of Death		4c. County of Death			-L						
	CHESTE	R RIVE	R MANOR	CHESTER	RTOWN				KENT						
	5. Social Security N		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bir	th Yes		9. Birthp	place (State or Foreign		
	156-07-	5904	88	Yrs.	Months Days	Months Days Hours Min.			8. Date of Birth (Month, Day, Year) 3/8/1921			DE DE			
	Usual Residence of					3/0/12									
	10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limits			
호	MD KENT ROCK HALL											14 Yes 2 □ No			
rec	10e. Street and Nur	L			10f. Zip Code			10g. (	g. Citizen of What Country?						
Funeral Director	205 CHES	SAPEAKI	E VILLA			21661			U	USA					
Jers	11. Marital Status		12. Was Dec	edent Ever in U.S	S. 13.1	Was Decedent of If Yes, specify Cub	e - Americ	can Indian,							
Ē	1 ☐ Never Marri	ied 2□ Mar	Armed F rried 1 ☐ Yes			ck, White,	etc.								
Ď	3 🕅 Widowed	4 Divorced	I If Vac G	ive		1 □Yes 2X No Specify: Specify: WHITE									
Completed by	(0	15. Deceder	nt's Education		16a. Dece	dent's Usual Occu	pation			16b.	Kind of B	usiness/In	dustry		
lg.	Elementary/Seco	· · · ·	est grade completed	1-4or 5+)	life.	kind of work done DO NOT use retire	auring mo ed)	st of work	ing						
Š	7	maary (0 12)		1 701 017	HOMEM	1AKER									
Be C	17. Father's Name	(First, Middle,	, Last)		18. Mother's Name				e (First, Middle,	, Maide	en Surnan	ne)			
P	ROBERT B.	. CROS	S				UNK	NOWN							
Г	19a. Informant's Na	ame/Relations	ship (Type. Print)		19b. Mailir	ng Address (Stree	t and Numi	ber or Rur	ral Route Numb	er, City	y or Town,	State, Zip	Code)		
	ALLEN W	ILSON/	SON		2111	6 STRIPE	R RUN	, RO	CK HALL	, M	D 21	661			
	20a. Method of Disp			-	lace of Dispo	sition (Name of matory or other pla	100)	- [	Date	20c.	Location -	- City or To	own, State		
	1 □XBurial 2 [ 4 □ Donation		3 ☐ Removal from	State			1	10/7	100	OT 4	DIZCO	O.D.O.	NT T		
				EGL	22	CEMETER  Name and Addr	ess of Faci	<u>10/7</u> lity				ORO,	•		
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620														
	23a. Part 1. Enter the disease, or complication of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate														
	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death												Onset and Death		
	disease or condition a. SSS DACTET, WEEK											1 week			
	Due to (or ds a consequence of):												6 mo's		
ē	Sequentially list conditions, if any, leading to immediate Due to las a consequence of):											- 1	0 10 5		
듩	cause. Enter Underlying Cause (Disease or Injury that initiated events  C.														
Xa	resulting in death) I	Last	c	(or as a consequ	ence of):										
/Medical Examiner			d												
edi															
	IF FEMALE: 23b. Was decedent	t pregnant		tcome of pregna		_						ite of deliv	ivery		
icia	in the past 12 1 ☐ Yes 2 ☐	months?	4 Pre	birth 2 Tetal gnant at time of d		⊒ Ectopic pregnan ⊒ Other <i>(specify)</i> <sub>-</sub>	Ectopic pregnancy Other (specify)						Day Year		
Physicia	9 Unknown		9 □ Unk	nown											
y P	Part II. Other signif	ficant conditi	ions contributing to	death but not resu	ılting in the u	in the underlying cause given in Part I. 23e. Did to						tobacco use contribute to the cause of death			
Completed by	PAD	Coer	iph. Vasa	lar li	s .)	Hype	tens	100	1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably					
lete		•	•		/				24a. Was	Was an 24h Were autons			opsy findings available		
Ĕ									auto	psy ormed?	,	prior to co death?	completion of cause of		
1   Yes 2   N									Vo	1 ☐ Yes	2500				
Be	examiner?		Hospital:			Ot	hor:		h (Check only o		- 7				
Ë	27. Manner of Deat		28a. Date	Inpatient 2	28b. Time of	nt 3 🗆 DOA	4 🖰	Vursing Ho	ome 5 ☐ Resi 28d. Describe				fy)		
io	1 Natural	5 Pendir	ng (Mo	nth, Day, Year)	Injury	Wo	rk? ]Yes 2[		Zod. Dosoribe	11011 111	jury occur	, cu			
3 Suicide 6 Could not be 280 Place of Injury. At home form street feeten effice.									al Route Number						
4 Homicide determined building, etc. (Specify)  City or Town, State)										Jei oi rian	Hurai Houte Number,				
ŏ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s											stated			
Medical	(Check only one)	2☐ Medical	Examiner: On the	basis of examina nner stated.	tion and/or in	vestigation, in my	opinion, de	eath occur	ace, and due to the cause(s) and manner as stated. courred at the time, date and place, and due to the cause(s)						
Me	29b. Signature and	title of certifie	29c. Licen	29c. License number 29d						Day, Year)					
	•	1	, )	. ~				10/8/20							
	20 Nama and add	7	who completed cau	(N)	22a) /T.m.=	Drint\	D51	15	ر	1	- 13	101			
	Frederic		. De l b					100	10-10	ha	slor	1-	MAZICZO		
te	31. Date filed (Mon			Regis ar's Signal	ture •	WC CY	LUISY	1+11	IKCI.	_Y V	J751	100	1, MD21620		
ar			n @ 2000	Manual.	, A	back									

			for State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of	Health and I <i>Death</i>	Mental Hyg Re	iene 2009	34251
	Physici		1. Decedent's Name (First, Middle, Lo Rena	R.	Soude	rs		2. Date of Deatl		3. Time of Death 2:35 pm <sup>M</sup>
	/Medio Examin		4a. Facility Name (If not institution, gi Devlin Manor N	ive street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	· · · · · · · · · · · · · · · · · · ·
ı	Funeral Director		5. Social Security Number 6.		(In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 26		place (State or Foreign intry) PA
	aryland show	,	Usual Residence of Decedent  10a. State 10b. County  MD Allect	gany	10c. City, Town or Lo பே	cation mberland				10d. Inside City Limits 1 □¥es 2 □ No
	vith the Mi or 28a-f	Director	10e. Street and Number			10f. Zip Code	04500	11	Og. Citizen of What Cou	intry?
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, It a Madical Experience in set be multified at	Funeral	10301 Christie   11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No.} \)			21502 Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	ican Indian,
Maryland 21215-0036	hours aft atural", or	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □ No dent's Usual Occup	Specify:		Specify: W	hite
21215	I within 72 giene. r than "ne If e Madi	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire emaker	during most of wor	king	own home	ŕ
land	e d tal	To Be C	17. Father's Name (First, Middle, Las Spurgen Dea	•			1	ne (First, Middle, N Ella Kok	naiden Surname) iner Deaner	
	12 s thar 7 is trau		19a. Informant's Name/Relationship Ruth Parker	(Type. Print) dau	ghter 43	ng Address (Street B7 Ascens	and Number or Rusion Stree	ural Route Number, t Cum	City or Town, State, Zinberland	MD 21502
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition  1 💆 Burial 2 🗆 Cremation 3 🗈  4 🗆 Donation 5 🗀 Other (Speci		20b. Place of Dispo cemetery, cren Restlawn	sition (Name of natory or other plac Memorial G	<sup>ce)</sup> ardens	Date 2 10/23/2009	20c. Location - City or T LaVale	own, State
Balt	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Lice		22		iellî Funeral H Zirginia Avent		nd, MD 21502	
	Physician /Medical Examiner		23a Part . Enter the disease, ir consports, or heart failure. List only limited that cause (Final state or constitution) assets of constitution in death.	a. Coro		er the mode of dyli	ng, such as cardiac	c or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	incate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to manage accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				19	
.O. Box 62	To the hospital of Attending Prysician: The law requires that the death certific, within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending placompletely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ∰onths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		23d. Date of deli Month	very Day Year
cords, P	jures tnat n signed t Ild be deta	þ	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to s 2 No 3 □ Pro	the cause of death?
Ital Reco	I ne law requ cate has been page 2 shoul	Completed						24a. Was ar autops perform 1 □ Yes 2	y prior to c ne <b>d</b> ? death?	opsy findings available ompletion of cause of 2  No
<u> </u>	siciar certif rectoi	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		oth		th (Check only one		
5	ral di	T	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier 28b. Time of	N 3 L DOA		lome 5 ☐ Reside 28d. Describe ho	nce 6 Other (Spec	ify)
<u>.</u>	naing ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		Wor	k? ]Yes 2 □ No	2001 20001120 110	n njarj oddanou	
DIVISION	al or Arre s after dea al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		/ - At home, farm, str (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	ne nospir in 24 hour he Funera pletely fille	Medical (		hysician: To the best of miner: On the basis of eand manner state	xamination and/or in					
	North Con	Σ	29b. Signature and title of certifier	Jufmo		29c. Licens	ose number		Oct 21,	Day, Year)
			30. Name and address of person who SUNIL GUPTA,				NBERVAN	o, mo	21502	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1.41				

DHMH 17 Rev 1/2001

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			State Registrar	State of Ma	ryland		rtment				F	eg. No. 2	009	34252	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		~~						Date of Dea     Month	Day	Year	3. Time of Death	
200	/Medic		THOMAS TRAIL		SR.			-			OCTOBER		2009 unty of Death	12:34 P M	
	Examin	er	4a. Facility Name (If not institution, give single FREDERICK MEM		ΤΛΊΤΤ	٠.	4b. City,	iown, or IDERI		or Death			DERICK		
	Francis		5. Social Security Number 6. Sex			st birthday)	If Under		If Under	24 Hrs.	8. Date of Birth	1	9, Birth	place (State or Foreign	
	Funeral Director			маПе	73	Yrs.	Months	Days	Hours	Min.	July 24,		Coui Mary	land	
•			Usual Residence of Decedent				1								
	rylan show	_	10a. State 10b. County Maryland Frederi		10c. City,	Town or Lo		ederi	ck.				'	0d. Inside City Limits 1    1   Yes 2   No	
	Ba-f s	Director													
	be filed within 72 hours after death with the Maryland rial Hygiene.  did other than "natural", or items 23a or 28a-f show event, the Hadieal Evanimer nitster is difficult.		10e. Street and Number 26 East Third Street,	Apartment	1		10f. Zip		21701			10g. Citizer	of What Cour <b>Unite</b> d		
	death	Funeral	11. Marital Status	2. Was Decedent E	ver in U.S.	. 13. \	Was Deced	ent of His	spanic Or	igin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
9	after or ite		1 ☐ Never Married 2 🔀 Married	1 □Yes 2 No	0		1 □ Yes 2		Specify.		riiodii, oto.)			ite	
00	ural",	d by	3 Widowed 4 Divorced	Year or Dates:											
2	"nati	lete	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done d	urina mos	st of work	ing	16b. Kina	of Business/In	austry	
21215-0036	within ene. <b>than</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)		d Cust					Faith	Based Or	ganization	
0 0	filed Hygid		17. Father's Name (First, Middle, Last)						18. Moth	er's Name	e (First, Middle,	Maiden Su	rname)		
ylan	2 should be f and Mental I is marked or is marked or aumatic eve	To Be	Clarence E Speak Sr. Lillian I. Trail												
≥	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type Sherry Harris / Daugh	,							al Route Numbe ick, Mary			o Code)	
=	s 1 a of Hei Item		20a. Method of Disposition		20b. Pla	ace of Dispo metery, cren	sition (Nan	ne of ther place	9)		oate er 23,	20c. Loca	tion - City or To	own, State	
<u>E</u>	Pages ment of I ant: If Ite ury or o		1 🔀 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		nt Öliv				200		Frede	erick, Ma	aryland	
Baltimore,	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Livens	L.	M01	433   22 433   1	Name and Reeney	d Addres	s of Facil	P.A.	Funeral H	ome	eviland 21	1701	
		1 10	23a, Part 1. Enter the disease, or complic	cations that caused									Ly Land 2	Approximate	
	Thurstein.	2	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition											Interval Between Onset and Death	
No.	Physician /Medical		resulting in death)												
ASS.	Examiner			Ac	nte	Z V	en	al	-	ail	ure				
h.,		ner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events)												
	cate be executed bhysician and the burial-transit	Examiner	Cause Chief on the right of the control of the cause of injury that initiated events  c.   The thought of the control of the cause of t												
Ó,	e exe ian a urial-1		resulting in death) Last	Due to (or as a	conseque	ence of):									
8760,	ate b ohysic the bi	dical	d												
Вох 6	leath certific attending pl	Physician/Mec	IF FEMALE:	Re If was outcome	of pregnan	acv.							d Data of dath		
Bo	attendatter	ian,	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at	2 🗌 Fetal	death 3[	☐ Ectopic p☐ Other (sp		1			23	d. Date of delive Month	/ery Day Year	
o	he de the	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	time or de	alli 5L	Tottlet (st	ecity)						_	
σ.	res that the de sign <b>e</b> d by the a I be detached t		Part II. Other significant conditions con	tributing to death bu	t not resul	ting in the u	nderlying c	ause give	n in Part	1.	23e. Did to	obacco use	contribute to	the cause of death?	
ds	uires n sigr ld be	d by									1 🗆 1	res 2	No 3□ Pro	bably 4 ☐ Unknown	
S	w require s been sig	Completed									24a. Was	an	24b. Were aut	opsy findings available	
<u>e</u>	he law e has age 2 a	шć									autor	rmed? 24 No	death?	ompletion of cause of	
ta	ician; The certificate ector, pag		25. Was case referred to medical						26 Plac	e of Deat	l 1 ∐Yes th <i>(Check only</i> o		1 □Yes	2 □No	
<u> </u>	Physician; The this certificate h ral director, page	o Be	examiner? /	ospital: 1 Inpatie	nt 2 □ E	ER/Outpatie	Othor						Residence 6 Other (Specify)		
9	g Phys ter this neral dii	Ë	27. Manner of Death	28a. Date of Injur (Month, Day	v	28b. Time o Injury		8c. Injur	y at		28d. Describe I	escribe how injury occurred			
<u>ō</u>	ath. r: After	atio	1	(WORLIT, Day	, reary	Injury	M		Yes 2□	]No					
Division of Vital Records,	I or Attencattater death	tific	3 ☐ Suicide 6 ☐ Could not be determined	me, farm, str	reet, factory	, office				Location (Street and Number or Rural Route Number, City or Town, State)					
ō	ital o Irs aft ral Di	Se	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide  28d. Describe how in North Homicide												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examination	sician: To the best on ner: On the basis of and manner sta	examinati	vledge, deat ion and/or Ir	th occurred ovestigation	at the tir n, in my o	ne, date a pinion, de	and place eath occu	, and due to the rred at the time,	cause(s) a date and p	ind manner as lace, and due	stated. to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier	^			296	c. Licens	e number			29d. Date signed (Month, Day, Year)			
			· m	NA				MD03	35106			10/19/2009			
			30. Name and address of person who co			, , , , .						-	_		
			Myung Hee Nam, M.D.	400 West S			t, Fred	leric	c, Mar	yland	21701				
	Sta		31. Date filed (Month, Pay Year)	009 32. Registra	ar's Signati	ure	BONK	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2000 34253

		1- For State Certificate Registrar	of Death	Reg. No.	9 3423
Physici ledical Exami	an/	1. Decedent's Name (First, Middle,Last)  CeCeilia C. Todd-Dixon		2. Date of Death  Month Day Year September 21, 2009	3. Time of Death 0840 hrs
Teulcal Exami	ilei	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	th
		2507 Arundel Road #2  5. Social Security Number	Mt. Rainier  y) If Under 1 Year If Under 24Hrs	Prince Georges. 8. Date of Birth(MM/DD/YYYY) 9. B	
Funeral Director		578-88-7461 X 41	Yrs. Months Days Hours Mir	Fore	
any	H	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Aaryland 28a-f show any 1.at once	ē	MD Prince George Upper	Marlboro		1 X Yes 2 No
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho numatic event, the Medical Examiner must be notified at once	_	10e. Street and Number 14139 Spring Branch Drive	10f. Zip Code 20772	10g. Citizen of What Co	untry?
death with r items 2 nust be n	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>		erican Indian, Black,
s after er ral", o	by F	Widowed 4 X Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	Specify:Bla	
2 hour "natu	eted		ing most of working life. DO NOT use ref		s/maustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " or other traumatic event, the Medical.	Completed		omecare	Prvt	
:15-C filed v al Hygi ed oth nt, the l	ابه	17. Father's Name (First, Middle, Last)  Robert Brown Sr		e (First, Middle, Maiden Surname) Wilson	
212 ould be d Ment s mark	_	19a. Informant's Name/Relationship (Type, Print ) 19b. N	failing Address (Street and Number or	Rural Route Number, City or Town, Sta	
MD nd 2 sh alth an m 27 i		Robert Brown Jr (Brother) 41	27 Minnesota Av isposition (Name of cemetery,	e NE Washington	DC 20019
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Bygene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		Burial 2 X Cremation 3 Removal from State Rivero	or other place) lale Crematory 1	0-5-09 Riverda	le MD
altim mit. Pa partmen portani		4 Donation 5 Other Specify:	22. Name and Address of Facility A . S		
		suy E/sura	7908-B Kincanno	on Pl, Lorton V	
Physician /Medical	(	23a. Part I. Enter the disease, or compilications that caused the death. Do not enfailure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic C		or respiratory arrest, shock, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Typertensive Atheroscierotic Control of the control of the	didiovasculai Disease		_
	Ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			_
	mine	cause. Enter Underlying Cause (Disease or injury that initiated			-
uted nd ransit	I Exa	events resulting in death) Last Due to (or as a consequence or):  d.			
760, icate be executed physician and the burial - transit	edical	UNPENDED AMENDED			
8760, ifficate being physic sthe burthe Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	23d. Date of deliver	ery Day Year	
Box 687; death certificate attending	Physician	4 Pregnant at time of death 5	Other (Specify)		
O. Be t the de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
ires that the signed by a detach	d by	morbid obesity, diabetes mellitus		1 Yes 2 No 3 Pr	
ords w requi	Completed			autopsy prior to	autopsy findings available completion of cause of
Reco	Com				Yes 2 No
Vital Reco hysician: The law this certificate has al director, page 2 s	o Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outp.	26.Place of Death (Check atient 3 DOA Other Nursi	ng Home 5 Residence 6 ✔ Oth	ner: Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after cleath.  al Director: After this certificate has been seled in by the funeral director, page 2 should I		27. Manner of Death 28a. Date of Injury 28b. Tim	ne of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Sion Attendi r death. ector: by the f	catio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	28f. Location (Street and Number or I	Dural Pouto Number City
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be executed ours after death.  eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined (Specify)	, street, factory, office building, etc.	or Town, State)	Rufal Route Number, Gity
the Hosp hin 24 hor the Fune	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Physician: To the best of my knowledge, death one)	occurred at the time, date and place, an estigation, in my opinion, death occurred	d due to the cause(s) and manner as st at the time, date and place, and due to	ated. the cause(s)
To wit	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (A	Month, Day, Year)
<b>D</b> '		Mlu Brundle de	O.C.M.E.	September 22,	2009
		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD	21201	
	tate	31. Date filed (Month, Day, Year) 22. Registrar's Sign lure	while .		
Regis	trar	OCT 13 2009 Server B. 190			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 8 2009 ear ELSIE 2:58A. Μ. TINSLEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 226-24-5559 83 Aug.#30°, 1926 VifgThia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Crofton 1 □Yes 2 No Maryland Anne Arundel Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2306 Putnam Lane 21114 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ⚠ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 □ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager retail sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Fitzgerald Mattie Elick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy R. Tinsley -son 8328 Quentin Street New Carrollton, Maryland 20784 20a. Method of Disposition

YE Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Arlington National Cemetery 11/9/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Liceus Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Athenoscherotic Heart disease or condition resulting in death) J-Pars /Medical Due to (or as a consequence of) Examiner with Thrombo Cytopenicy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 Probabiy 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ R/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 1. Natural 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

s after deau.
ral Director: Aft within 24 hours aft

To the Funeral Di

completely filled in

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number 20108

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, M.D. 14300 Gallant Fox Lane, #222 Bowie, Maryland 20715

State Registrar

Medical

31. Date filed (Month, Day, Year) 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 12, 2009 **Physician** 1:45 Yun Fu Ting /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery Village Healthcare Center Montgomery Village If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
Aug. 22, 1927 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1. **X**M 2□ F China Director 229-21-0731 82 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evandrar roust be notified at 1XYes 2 No Director Gaithersburg Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20878 782 Quince Orchard Blvd., # 102 United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify Specify: 3 Widowed 4 Divorced Asian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Restaurant is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shi ပ္ Hai-Geng Ting 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type. Print) Steven Ting/Son 782 Quince Orchard Blvd., # 102, Gaithersburg, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/16/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner b. Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner be executed Cerebrovascular Vascular Accident physician and the burial-tran Due to (or as a consequence of) Physician/Medical Hypertension law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 TYPS 2 NO Ö 9 Unknown signed by t I be detach σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page, certificate 2 X No 1 □Yes 2 □No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division J within 24 hours after death.
To the Funeral Director: Aftr 5 ☐ Pending Investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jany 10 October 12, 2009 D 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Germantown, Maryland 20874 Vinu Ganti, M.D., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1 3 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12 2009 10:30 AM Clarene E. Thurman October 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rising Sun Cecil Calvert Manor Healthcare Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Hours Days 1 □ M 2 Ϊ F Yrs. 21, 1919 Texas 451-28-8312 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland Ceci1 North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 United States 56 Racine Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Beauty Industry Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Judson Earhart Lilly Bell Foust 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21901 Shirley Duckenfield / Daughter 56 Racine Road, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October Pine Forrest Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 16, 2009 Pine Forrest, Texas 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Crouch Funeral Home

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany or other traumatic event **Physician** /Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ural", or items 23a or 28a-f show | Examiner must be notified at

"natural", or

than

marked other

Injury or other traumatic event, the Medical

Director

Funeral

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Completed

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the Maryland

filed within 72 hours after Hygiene.

Maryland 21215-0036

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R

Examiner

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attending physician

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death.

within 24 hours after death To the Funeral Director:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disa shock, or heart failur

Immediate Cause (Final disease or condition resulting in death)

ase, or	complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.  a. Due to (or as a consequence of):	a	Approxim Interval B Onset an	d Death
s, te	b			
·	c			
ant s?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of de Month	livery Day	Year

Examine Physician/Medical g Completed Be Certification: To

IF F	EMALE:
23b.	Was decedent pregnant
	in the past 12 months?
	1 ☐ Yes 2 X No
	9 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe No XX

25.	Was cas	e referred to medica
	1 ☐ Yes	2 No

Natural

29a. Certifier

1 🔲 inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

and manner stated.

Hospital:

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

127 South Main Street, North East, Maryland21901

2 Accident 6 □ Could not be 3 ☐ Suicide determined 4 | Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	one)	1	) INEC
006	Cinnburg d	ad little	of on

oria

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

26. Place of Death (Check only one)

ame and address of person who completed cause of death

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07719 State of Maryland / Department of Health and Mental Hygiene Marlene M. Turnage 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 5, 2009 0835 hrs TURNAGE Medical Examiner MARLENE Μ. c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Social Security Number Hours Months Davs Director 1 M 2 X F 58 07/09/1951 577-76-2355 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygener
Important: If iten 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. MD Anne Arundel Millersville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8304 Hope Point Ct. 21108 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify Black Yes. Give Yea Yes 2 X No specify: Widowed 4 X Divorced ⋧ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 2yrs of Aging Specialist Dept. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Brown John E. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Burnie, Md. 2106 20c. Location - City or Town, State 7883 Tall Pines Ct. #H Annazette Turnage – Daughter Glen 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 10-12-2009 Suitland, Md Lincoln Cemetery Donation 5 Other Specify 22. Name and Address of Facility
Marshall's Funeral Home of Maryland
4308 Suitland Rd. Suitland, MD. 20746 21. Signature of Funeral Service License Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial -Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) ģ Completed

The law requires that the death certificate be executed certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 1 Division of Vital

Be

Certification: To

Medical

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Regist

1 Yes 2 No 9 V Unknown	g Unknown	0 0 (-)-				
Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlyi	ng cause given in Part I.		acco use contribute to	
			_	24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
25. Was case referred to medical		<del></del>	26.Place of Death (Check	( only one)		
	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nurs	ing Home 5 R	esidence 6 Other	:
27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month Day Year) Oct 5, 2009	28b. Time of Injury 0800 hrs	28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe ho Pedestrian st	w injury occurred ruck by auto	
2 Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At ho		ory, office building, etc.	or Town Sta		ral Route Number, City en Burnie, MD
29a. Certifier (Check only one)  2 Medical Examiner: C	n: To the best of my knowledge to the basis of examination a nd manner stated.	ge, death occurred at t nd/or investigation, in	the time, date and place, an my opinion, death occurred	d due to the cause( at the time, date ar	(s) and manner as stat nd place, and due to th	ed. e cause(s)
29b. Signature and title of certifier	nu manner stateu.		29c. License number		29d. Date signed (Mo	nth, Day, Year)

Year

October 6, 2009

OCME

31. Date filed (Month) Registrar

State

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10 18 2009 JANET A. THOMAS 11.00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY 88 HAWTHORNE DRIVE FROSTBURG Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 🔀 F Yrs 1935 WEST VIRGINIA 20 Director 234-58-0211 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience traumatic event, the Medical Experience traumatical Additional Experience to the Additi 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □ No Director MD ALLEGANY FROSTBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 88 HAWTHORNE DRIVE 21532 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT PROFESSOR UNIVERSITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IDRIS J. THOMAS MARGARET DUBOIS THOMAS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 ls Department of Health Important: If item 27 any injury or other trong. CAROL CLEVELAND TEABERRY LANE FROSTBURG,
Disposition (Name of Date FRIEND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY 10-19-2009 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME. P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final FROSTBURG, MD 21532 Approximate Interval Between Onset and Death Immediate Cause (Final whenter **Physician** ar disease or condition resulting in death) /Medical Duclo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.0. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy or Attending Physician: The 2 NO 2 No 1 Tyes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 📉 📉 🗖 0 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After th funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 TYes 2 □ No hours after death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

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of death (Item 23a) (Type, Pr

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completed caus

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30. Name and address of pe

Year)

State Registrar

Maryland 21215-0036

Saltimore.

Box 68760.

P.0.

of Vital Records,

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARGARET IDA VARNELL TOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner CHAR PLATA LA CIVISTA MEDICAL CENTER 206308 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2 – 7 – 1937 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 KF Days Hours 72 577-50-3534 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f show MD. CHARLES LA PLATA traumatic event, the Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 5020 SKYLARK DRIVE 20646 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, MARGARE 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married ō 1 ☐ Yes 2 ☐ No Specify. Specify:WHITE 2 Baltimore, Maryland 21215-003 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ROBERT BEACH MARION RIDGEWAY ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 i ROY R. VARNELL, JR.-SON 5020 SKYLARK DR. LA PLATA, MD. 20646 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o tot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State TRÏNÏTŸ MEM.GARDENS 10-24-09 WALDORF, MD. 4 Donation 5 Other (Specify) M0047921. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Mulle LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one call each line. Don of Inter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 3511 **Physician** 12 DUIL disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury Examiner Due to (a) as a consequence of): resulting in death) Last Due to (or as a consequence of):

The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760. the o signed by to d be detach ۵. of Vital Records, peen cate has page 2 s certificate this funeral After Division Hospital or Attending after death.

I Director: Af in by the fur

Approximate Onset and Death Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 10 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

34260

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Year

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Black, White, etc.

2009

State Registrar 30. Name and address of pers

31. Date filed (Month, Day,

121018

Year)

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filled in by

within 24 hours a

To the Funeral D

cause of death (Item 23a) (Type, P

32. Registrar's Signature

		For State Registrar	State	of Marylan	•	artment of F		Mental Hy	/giene Reg. No. <b>2</b> ()	09	34261
		Decedent's Name (First, Middle)	, Last)					2. Date of D	eath		3. Time of Death
Physicia /Medic		HELEN ELIZ	ABETH	WILSON				Oct.	10 <sup>Day</sup> 2009	Year	19:45 M
Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location of Dea	th	4c. Count	of Death	
		Prince Georges	Hospital			Chever			Princ	e Ge	orges
Funeral		,	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	lav. Yearl	9. Birth	place (State or Foreign ntry)
Director		579-46-2370	1 W 2 E3 F	73	Yrs.			Aug.	18, 1936		DC
and w		Usual Residence of Decedent  10a. State 10b. County		10c, City	y, Town or Lo	cation		· · · · · ·			I Od. Inside City Limits
f sho	ō		Georges	Lan	dover						1 □Yes 2 No
the N	Director	10e. Street and Number	deorges	Бан	Idovei	10f, Zip Code			10g. Citizen of	What Cou	ntry?
3a or		6602 Asset Dr.				20785			USA		
death	Funeral	11. Marital Status	12. Was De	cedent Ever in U.	S. 13. \	Was Decedent of H	lispanic Origin? (	Specify Yes or N		ce - Ameri	can Indian,
or ite		1 ☐ Never Married 2 ☐ Marri	Armed F 1 ☐ Yes	2 2 No		fYes, specify Cuba 1 □Yes 2⊠No	an, Mexican, Pue Specify:	rto Rican, etc.)		ck, White,	etc.
ours a	d by	3 Nidowed 4 Divorced	If Yes, G Year or	Dates:		ILITES ZENIO	оресну.		Speci	y: B1a	ack
72 h	Completed	15. Decedent (Specify only highest	's Education t grade completed	0	i (Give	dent's Usual Occup kind of work done o	durina most of wo	orking	16b. Kind of E	lusiness/In	dustry
ithin han han han han han han han han han ha	ш	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retired	1)	-	, .	C A	
Hed w		17. Father's Name (First, Middle,	2 y	rs	Secr	etary	18 Mother's Ma	me (First Middl	Dept. c		ay
to be fi	Be	Lorenzo Willia	,						n Wroten		
hould Me mark	ပ္	19a. Informant's Name/Relationsl			19h Mailir	ng Address (Street					n Code)
nd 2 s lith ar 27 is rtrau		Diane Taylor -			1	Asset Dr			· ·	, 51015, 2,	, 5555,
ifem star		20a. Method of Disposition	Daughter			sition (Name of natory or other place		Date	20c. Location	- City or To	own, State
ent o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State		o1n Cemet		19-2009	Brentw	ood.	Mđ.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Marical Examinact ust the notified at once.		21. Signature of Purperal Service		. / .		Name and Addre					114.
B a T E B		1/laters	o C.U	Tods		308 Suitl			nd, Md.		3
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	n. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
- Physician		Immediate Cause (Final disease or condition	A	COTT	PC	IL MUN	ARY	ED ET	MA		Onset and Death
/Medical		resulting in death)	a. Due to	o (or as a consequ	uence of):			-A-0-	CALL	120	72hr
Examiner	.	Sequentially list conditions	b. HC	NTE	CON	166 X1 1	VE H	EIM	MIC	W.	Tany
pe #is	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a consequ	uence of):	VE H.	TAK	DIDE	ASI		20 4R.O
be executed ician and ourial-transit	хаш	that initiated events resulting in death) Last	U	o (or as a consequ			21(11			-	0 0 0 0 0
s be executed sician and burial-transit				o (or as a consequ	301100 017.						
phy the	edical		d								
eath certific attending for use as	Ž	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna					23d. D	ate of deliv	ery
death a atte	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 □ Pre	e birth 2 - Fetal gnant at time of d		Ectopic pregnanc Other (specify)	у		М	onth	Day Year
that the dended by the detached	Physician/Me	9 Unknown	9 □ Unl	known							
	by P	Part II. Other significant condition	ns contributing to	death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	tribute to	the cause of death?
w require been sign	ed	HOUTE		MONI		0-17		.   1	Yes 2 No	3∏ Pro	bably 4 ☐ Unknown
law re as be 2 sho	Plet	HISTORY O	- BRG	430)	ANC			24a. Wa	s an 24b.	Were aut	opsy findings available ompletion of cause of
The cate ha	Completed							per 1 □ Yes	formed?	death? 1 ☐ Yes	•
lcian: The certificate ector, pag	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only			
hysic this o	٥	1 ☑ Yes 2 ☐ No			ER/Outpatier		4 L Nursing		sidence 6 🗆 Ot		fy)
Attending Physician; r death. ector: After this certific. by the funeral director,		27. Manner of Death 1 ☐ Natural 5 ☐ Pending		e of Injury onth, Day, Year)	28b. Time of Injury	Worl		28d. Describe	how injury occu	rred	
ttend feath tor: / the f	cati	2 Accident investig	ot ho	6 luium - A4 lu			Yes 2 ☐ No	206	(Ot	6 an an D	al Davida Niverbay
or At after of Direc in by	Certification:	4 ☐ Homicide determ	20e. Plac	ce of Injury - At ho ding, etc. (Specify	y)	eet, ractory, office		City or To	(Street and Num own, State)	per or Hur	al Route Number,
spital ours eral filled		29a, Certifier 1 Certifyin	o Physician: To th	ne best of my kno	wledge, deatl	h occurred at the tir	me, date and pla	ce, and due to th	e cause(s) and r	nanner as	stated.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2☐ Medical one)	Examiner: On the and ma	basis of examina inner stated.	tion and/or in	vestigation, in my o	ppinion, death oc	curred at the time	e, date and place	, and due	to the cause(s)
To th Voithir Comp	Me	29b. Signature and title of dertifier	1Don	7 1210		29c Licens	e number		29d. Date sign	ed (Month	Day, Year)
			M	you.		100	1819:	7	10-1	3-	2009
11		29b. Signature and title of dertifier 30. Name and address of person	who completed car	use of death (Item	123a) (Type,	Print)	MITIO	E I Al	LAND	ON	יכד מם
- T		31 Date filed (Month Pay Vocal	1 20	Regi <b>l</b> rar's Side	ture c	FICILI	-/	-C CIV	, ~ 1/00	V . I	-120119
Sta Registra	te ar	31. Date filed (Month, Day, Year) 0CT 1 3 2009	Deneur	Registrar's Signa	Kel						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 0 **Physician** GEROLINE WATSON 2009 SHARON 12:24p M OCT. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOLY CROSS HOSPITAL Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Hours Days Min 1 M 2 X F 239-70-1385 Feb. 5, NĆ Director 66 1943 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c, City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shov oficel Examiner must be notified at 28a-f shov 1 ☐ Yes 2 No Directo MD Prince Georges Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7903 Orion Circle #063 20724 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Administrator unknown lvr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Watson, Sr. ၉ Rosie Lee McDuffie of Health and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7903 Orion Circle #063 Laure, Md. 20724 Doncy Hetmeyer-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Oak Springs 10-18-2009 | Shelby, NC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Multiorgan Failure /Medical Due to (or as a consequence of) Examiner Sepsis with septic shock Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Clostridium difficile colitis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl Pulmonary embolish autopsy performed 1 ☐Yes 2 ☐ No Baldder Cancer 1 ☐ Yes 2 1 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, filled in I

Hospital or Attending Physician: after death Director: 24 hours a within 2 To the

State Registrar

DHMH 17 Rev 1/2001

completely

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 □Yes 2 □No

Medical

1 Natural

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifie

3 Suicide

29a. Certifier

5 Pending

investigation

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2<u>009</u> Physician/ Month October Linda G. Woodall 3:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kline Hospice House Frederick Mt. Airv Social Security Numbe 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min Director 215-56-7949 60 Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5718 Bartonsville Rd. USA 21704 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed Specify: 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Computer Technician Communication vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Lester Roche Woodall Alberta M. Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Woodall/ Brother 3269 Wendlyn Way, Edgewater MD 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory Edgewater, MD 10-05-2009 21. Signatu Trvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Melle 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysiciani colon disease or condition resulting in death) on yea Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Aho 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Telastien KMIROUZ 10/05/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sebastien S. Kairouz, M.D. 46B Thomas Johnson Dr., Ste. 200, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:40 04 70NN eptember 26,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** Months 1**x** M 2 □ F Director 58 221-34-7530 2/19/1951 Wilmington, Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director DE Examiner must be notified New Castle Townsend 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? U.S.A. 255 Union Church Road 19734 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No þ 3 Widowed 4 Divorced White natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other than Construction Contractor 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Frank L. Wiseburn Mary M. Ament 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> John Runyon/Step-son Reybold Drive, Delaware City, DE 19706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 9/29<sup>Date</sup>009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Injury or Services United Crematory Newark, DE Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC The state of the death. Do not enter the mode of dying, such as cardiac or respirating arrest, Approximate Approximate 19709 23a, Part 1. Enter the disease. shock, or heart failure. List le cause on each line erval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Spontaneas
Die to (or as a consequence or /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner a consequence of) noto cellular lor Attending Physician: The law requires that the death certificate be executed arunoma resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner?
1 \subseteq Yes Hospital: 1 Inpatient Other: 2 No 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home ၉ 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural
2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No filled in by the Director: 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 eptember 26,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 8, 2009 4:26 A M DEWEY F. WILSON, SR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death KENT CHESTERTOWN CHESTER RIVER HOSPITAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 □ F Min. Hours Months Days 11/25/1932 220-28-0624 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No QUEEN ANNE'S MILLINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 110 TEAT LANE 21651 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: KOREA Specify. Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIP. OPERATOR CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES WILSON BLANCH MOGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110 TEAT LANE, MILLINGTON, MD 21651 JANICE C. WILSON/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CRUMPTON CEMETERY 10/13/09 CRUMPTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MD

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Director

Completed by Funeral

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f short than "vedical Erations in its benefited at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, It \*\* \*\*\*

Baltimore, Maryland 21215-0036

burial-tran

Physician/Medical Examiner attending physician for use as the buria been signed by the should be detached Medical Certification: To Be Completed by certificate has l funeral ours after death.

neral Director: Al
filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Hur 74.74	370	W. CYPRESS ST.	MILLINGTO	N, MD 210	651
23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the death. Do not enter thone cause on each line.	ne mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE  Due to (or as a consequence of):	HEART FAI	LURE		5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):	LTERY DIS	EASE		>5 years
resulting in death) Last	Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy her (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant conditions c	ontributing to death but not resulting in the under	lying cause given in Part I.			o the cause of death? robably 4 🗍 Unknown
			24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 No
25. Was case referred to medical examiner?			ath (Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient :	3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence	6 ☐Other (Spe	ecify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accidentinvestigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death or niner: On the basis of examination and/or inves and manner stated.	curred at the time, date and place tigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier.	The un	29c. License number D00415	-	Date signed (Mont	th, Day, Year)

Registrar

State

Helen A 31. Date filed (Month, E

within 24 hours a

To the Funeral I

completely filled

Chestertown, UND 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygien 2009 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11,2<sup>Year</sup> 7:45P M **Physician** ELEANOR WISE WILSON October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Lutheran Village Carroll Westminster If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth 8/27/1912 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 97 Months Days Hours 170-30-3224 1 ☐ M 2X F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 23a or 28a-f ehow other then "natural", or Iteme 23a or 28a-f ehor vent, the Medical Exeminer must be notified at Westminster 1 X Yes 2 ☐ No MD Carroll Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 300 St. Luke Circle Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █️No "natural", or Iteme 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 SpecifiWhite δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if flem 27 is marked othing eny injury or other traumatic event angle. Be Jane Ann Kauffman William James Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. M. Dip Co. 2009 904 19a. Informant's Name/Relationship (Type, Print) 3116 Gracefield Road, Apt.113, Silver Spring Mary Ann Mallinson/Daugh. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fawn Grove Cemetery 10/17/2009 Fawn Grove, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 21. Signature Juneral Service License Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 1/2mon/10 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner obstructive Polmonary Dispass use as the burial-transit The law requires that the death certificate be executed RON and that initiated events resulting in death) Last Due to (or as a consequence of P.O. Box 68760, physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 Other (specify) his certificate has been signed by the a director, page 2 should be detached. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel DE Curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dire to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier ď Dr Walden cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28b,d,e&f per ME g896 10/30.09 TT
State of Maryland / Department of Health and Mental Hygiene 34267 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 20:02PM LIMOTHY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MORE If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1□M 2□F May 24, 1986 MD Director 219-11-0559 23 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho MD Allegany Cumberland 1 □ ¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 11107 Mexico Farms Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 □Xio Specify Specify: <u></u> 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. n/a or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Jill (Werner) Wilt Johnson **Bradley Wilt** ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 mother 11107 Mexico Farms Cumberland Jill Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2009 Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fundral Perviço-License 23a. Part Enter the disease comblic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I is to only on cause on each line.

Immediate Cause if inal disease or corruptor are sulting in de 7th. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to forme a considuence off Examiner JA, M physician and s the burial-transit The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the a P.O. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 3 ☐ Probably 4 🖫 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Yes 2 □ No 1 💆 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred subject driver of car struck guard rail and embankment and overturned or Attending 1 Natural 5 Pending 8:47<sup>ury</sup>am within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 10-14-09 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, building, etc. (Specify) Roadway 3 Suicide 28. Location (Street and No. 1) Ger of Rural Route Number 22 City or Town, State 7, 100 WB near MM 22 Have rstown, farm\_street, factory, office determined 4 Homicide Intersiali Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uloxi SY Baltimory 31. Date filed (Month, Day, 62. Registrar's Signature Year) State Registrar

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09-07876 Hai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rvey Yoder		State o	f Maryland / Depa	rtment of	Health	and	Menta	l Hyg	iene		206	19	3426
		l-For State Registrar	Cer	tificate of	Death			Lo	Reg Date of Death	. No.		3. Time	
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Harvey E.	Yoder					12.	Month Cotober 6,	Day 2009	Year		0 hrs
cuicai Exami		4a. Facility Name (if not institution, give s			b. City, Tov	m, or Lo	ocation of [		october o, a		inty of Death		
		1978 Dorsey Hotel Road	,		Grantsv	ille				Garr	ett		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under	_	If Under 2		B. Date of Birth			thplace	tate or
Director		217-65-8902x	м 2 F 23	Yrs.	Months	Days	Hours	Min.	May 7	,198	6 6	untry)	
	ŀ	Usual Residence of Decedent										Land Inc	ide City Limits
v any		10a. State 10b. County Md Garre		Town or Locati									res 2X No
land f shov	ē		323						110	- Citizon	of What Cou		22
Mary r 28a-	Director	10e. Street and Number 1978 Dorsey	Hotol PD		10f. Zip C				109	U.S		ilu y s	
r death with the Maryland or items 23a or 28a-f show any must be notified at once.			12. Was Decedent Ever in U.	P 42 W/o			anic Origin	2 (Spec	ify Yes or No-		Race - Amer	ican India	an, Black,
ath wi tems st be	Funeral	11. Marital Status  1 X Never Married 2 Married	Armed Forces?	IS. Wa	es, specify	Cuban, I	Mexican, F	Puerto Ri	can, etc.)		White, etc.		
ter de ", or i		3 Widowed 4 Divorced	1 Yes 2 X XNo	1	Yes 2	No	specify:			Spe	cify: W	hite	
urs af tural amin	d by	15. Decedent's Education (Specify only	or Dates:	16a. Deceden						16b. Kind	of Business	Industry	
72 ho	ee	Elementary/Secondary (0-12)	College (1-4 or 5+)	Farme	ost of worki	ng ille. L	JO NOT U	seremed	'		Far	-	
vithin ene.	Completed	0		ralme	- L	Lea		Name (F	irst, Middle, M	laidan Cur		111	
filed v Hygi d oth		17. Father's Name (First, Middle, Last) $Edwin  P.  Y$	oder			- 1			Slaba		name)		
21215-0036 unid be filed within 7 Mental Hygiene. marked other than cevent, the Medica	o Be	and the second s		19b. Mailing	g Address	(Street	and Numb	er or Rut	al Route Num	ber, City o	r Town, Stat	e, Zip Co	de)
AD 2 shou and 27 is 1		19a. Informant's Name/Relationship (Ty Edwin P. Yod	er	1978	Dors	еу	Hote	el R	d Gr	ants	vill.	e, M	ld 2153
e, h I and Health item		20a. Method of Disposition	20b.	Place of Dispos	sition (Name	of cem	etery,	ī	Date	20c. Loca	ation - City o	r Town, S	tate. 15558
mor Pages ent of nt: If		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Ni	crematory or ot	n Ami	sh	Cem	get	9, 09	Salı	sbur	y, F	'a
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a nor 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1 3	21. Signature of Funeral Service Licens	ee	22.1	Name and A	ddress	of Facility	20	3 Nor unera	ţh,,S	t Me	yers	dale,
ii ii D D e iii	15	M Ray Lecke	mly										52 eximate Interval
Physician 'Medical		23a. Part I. Enter the disease, or complifailure. List only one cause on each	ch line.	i. Do not enter t	he mode of	dying, s	such as ca	raiac or r	espiratory arre	SI, SHOCK,	ornean		een Onset and Death
aminer	8 9		Muscular Dystrophy Due to (or as a consequence of	<b>√</b> f\•				_					Dodaii
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	ner	if any, leading to immediate Cause. Enter Underlying Cause	Due to (or as a consequence of	of):									
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executed an and al - transit	ũ	d										-	
a is is	dical	UNPENDED	AMENDED									_	
OX 68760, eath certificate be attending physici for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pred			3	Ectonic	pregnan	CV		oate of delive onth	ery Day	Year
c 68 certif ending use as	ciar	past 12 months?	4 Pregnant at time of d	ooth _	etal death ther (Speci		Lotopio	program	-,			,	
G 5 G 00	Physi	1 Yes 2 No 9 Unknown	9 Unknown										
P.O. s that the gned by redetache	by P	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying	cause gi	iven in Pai	rt I.					use of death?
S, P.C uires that n signed									24a. Was				indings available
cords law requi	bet								autop			complet	ion of cause of
Rec The la cate h	Completed								1 Yes	2 🗸 No	1	Yes	2 No
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner?	lospital:				of Death ( Other <sub>4</sub>			Posidons	e 6 🗸 Ott	or: Scen	
Division of Vital Records, tal or Attending Physician: The law requir at parter death.  al Director: After this certificate has been s led in by the funeral director, page 2 should t	ြို	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier			y at Work	<del></del>	Home 5 28d. Describe			iei. oceiii	
n of iding Pl h. : After e funera	<u> </u>	1 Natural 5 Pending	(Month, Day,Year)		,		res 2	- 1					
visio or Atter or Atter or Atter or Atter or Atter or Atter or Atter or Atter	icat	2 Accident Investigation	28e Place of Injury - At I	home, farm, stre	eet, factory,	office b	uilding, et	c. :			Number or	Rural Ro	ute Number, City
Div pital or ours afte reral Di	Certification:	3 Suicide 6 Could not to determined							or Town, S	State)			
Hos 24 h Fur		29a. Certifier	an: To the best of my knowle	dge, death occi	urred at the	time, da	ate and pla	ice, and	due to the cau	se(s) and i	manner as s	tated.	-(2)
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner	On the basis of examination and manner stated.	and/or investig				curred at	the time, date				
H % F 3	ž	29b. Signature and title of certifier			29c		e number				ite signed (/ per 15, 20		iy, Year)
		high, is				0.C.I	vi.⊏.			CCIOL	15, 20		
		30. Name and address of person who d		<sup>m 23a)</sup> 1 Penn Stre	et Baltir	nore	MD 212	201					
	10/2	31. Date filed (Month, Day Year)	32. Rejistrar's Signa	tura a	4								
	tate	OCT 262	109 /2	A A	anto	9							

State of Maryland / Department of Health and Mental Hygiene 34269 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 10, Day 2009 Year Iraida Zavístovich 7:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 😿 F Months Days Hours 152-26-7630 77 Director April 16, Russia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sho event, it a Medical Examiner must be natified at Director Maryland Prince George's 1 ☐ Yes 21XXNo Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 724 Tantallon Drive West 20744 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after and Mental Hygiene. 1 ∐Yes 2**∑** If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth Be If item 27 is marked or other traumatic ( Sergei Mishchenko Klavdia Mishina ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander R. Zavistovich / Son 221 Surrey Circle Drive Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott ★ Burial 2 Cremation 3 Removal from State Rock Creek Cemetery 10/14/2009 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Funeral gervice Licensee 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland farty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Imm diate Cause (Final Onset and Death **Physician** BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be execute physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. ☐Yes 2XXVo the 9 Unknown 9 Unknowi signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed certificate 1 □Yes 2**x**xxNo 2 🗆 No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2¥No Other: 4 Nursing Home 5 Residence NOTOTHER (Specify) Hospice Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred XX Natural 5 Pending To the Hospital or Attendiwithin 24 hours after death.

To the Funeral Director; A completely filled in by the fi death. investigation 1 □Yes 2 □No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Executifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. Kouerchou, mo 263748 October 11, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou MD 6001 Muncaster Hill Rd. Rockville, Maryland 20855 State OCT 1 3 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Armstrona 6:02 AM 2009 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Baltimore saltimore MO Birthplace (State or Foreign Country)
 N.P. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12–23–1940 Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Days Hours Yrs. 216-36-0192 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Owings Mills Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21117 9410 Owings Heights Circle # 101 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married African-American 1 ☐ Yes 🎾 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Substance Abuse Counselor Glen Wood Life 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Nixon George Armstrong Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Northgate Road, Baltimore, MD 21218 19a. Informant's Name/Relationship (Type. Print) Bridgette Foster Amstrong/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Durial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park 10-30-09 Arbutus, MD 22. Name and Address of Facility Wylle Funeral Home P.A. of Baltisons Or 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Panercatic disease or condition months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Obstructive Pulminary 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Hypertensur 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner the attending physician and hed for use as the burial-tran Physician/Medical signed by the

certificate

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after death Director: A d in by the f

within 24 hours aft To the Funeral Di completely filled in

To the Hospital or Attending Physician:

P.O. Box 68760

of Vital Records,

Examiner

Completed

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Medical Certification: To

**Physician** 

**Physician** 

/Medical

**Examiner** 

Funeral Director

Be

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If fleen 27 Is marked of her than "natural", or items 23a or 28a -1 show any injury or other traumatic event, it. Modes Exa. if wen must be required.

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 Suicide

5 Pending investigation 6 □ Could not be 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) October 24, 2009

6 West 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 West Towsentown Blid, Baltimore, Lip 21204 We

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi

or Town, State) 11 Spring Head t. F. Cockeysville, MD determined (Specify) residence Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🕡 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner

31. Date filed (Month, Day, Year) Registrar

Medical

. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar 34272 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Barnes 625 P Outobur N019 12 2009 /Medical Facility Name (If not institution, give areet and number 4b. City Town, or Location of Death 4c. County of Death Examiner 59/4:mo tospice If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2□F Months Days Hours Min. Director Usual Residence of Decedent 10b. County 10a, State City, Jown or Location 10d. Inside City Limits show other traumatic event, the Modical Examiner must be notified at 1 XYes 2 □ No Director more 28a-f 10e. Stre 10f. Zip Code 10g. Citizen of V 2120 items 23a Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturai". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than in injury or other traumatic event, Ite Insulation of the property in the Insulation of the Insulation of the Insulation of Insulation of Insulation of Insulation of Insulation of Insulation of Insulation of Insulation Insu Elementary/Secondary (0-12) College (1-4or 5+) 1,5ab 100 Unknown 17 Father's Name (First, Middle, Las. 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ (Siste Rural-Route Number, City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory of other p Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature f Funeral Service Ligenses Kul FUI Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heigh ailure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final deservices or condition resulting in death) **Physician** CANCER 6 minther /Medical Due to (or Q a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami and burial-tra Due to (or as a consequence of): inding physician a Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Po Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 2 No P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No 1 □Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Mother (Specify) Huspice After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred Division or Attending 1 - Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C To the Hospital 29a, Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) se Ribi Eytran Street Yorky Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 0 2009 Elisabeth Bryant Paula /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Severn 1851 Hawk Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 F Months Days Hours Min Yrs. 76 Director Oct 28, 1932 551-64-8151 Germany Usual Residence of Decedent 10d. Inside Cify Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes X☐ No Director Severn Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 United States 1851 Hawk Court Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Š 3 X Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental F Important: If item 27 is marked out any Injury or other traumatic even once. Be Pages 1 and 2 should be nent of Health and Mental ပ္ Johann Elisabetha Schonith-Muller Masseur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Bryant/granddaughter 1851 Hawk Court Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Nourial 2 Cremation 3 Removal from State Veterans Cemetery 10/30/2009 Crownsville, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licensee M00957 23a. Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final er 105 cherotie **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending ph for use as tl IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 No Month Day 5 Other (specify) ed by the detached f 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2,221No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?

Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No after death. 2 Accident filled in by the t 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the the 2 10 1 Name and address of person who repleted cause of death (Item 23a) (Type, Print) nv Jones 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Vital Records,

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Division

			1 - For State Registrar	State	of Marylar		artmer <i>rtificat</i>				-	_	2009	3427
			1. Decedent's Name (First, Midd	lle, Last)							2. Date of De	ath		3. Time of Death
	Physici /Medio		Claire Eileen	Bergeror	1						Month Octobei	Day 20	Year 2009	2:00 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution	nn, give street and r	u <i>mber)</i>		4b. City,	Town, or	Location of				County of Dea	
			Hillside Hou	se			Cla	rksv	ille			Н	oward	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under		8. Date of Bir	th	9. Bir	thplace (State or Foreigr
	Director		380-24-4001	1 □ M 2 <b>X</b> 2XF	81	Yrs.	Months	Days	Hours	Min.	(Month, Da July 12	iy, rear) 2,192	28	Michigan
	pg ,		Usual Residence of Decedent					1						
	rylar	_	10a. State 10b. County	1	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
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	ems	Funeral	11. Marital Status	12. Was De Armed I	cedent Ever in U		Nas Dece	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White	
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Maryland			19a. Informant's Name/Relations		<b>'</b> -							-	r Town, State, .	Zip Code)
	1 and 2 Health em 27 i		Joseph Octave	Bergeron/							Laurel,			
0	ges it of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from	n State	Place of Dispo cemetery, cren	sition (Nai natory or c	me of other place	) :	Oct.	23,	20c. Lo	cation - City or	Town, State
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		4 □ Donation 5 □ Other (5			st Arur			- 1	200	the state of the s		nton, MI	
Bai	ermit epar npor ny In		21. Signature of Funeral Service	Licensee	V									ne, P.A.
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			23a. Partil. Enter the disease, o shock, or heart failure. List	r complications that tonly one cause on	caused the deat each line.	th. Do not ent	er the mod	de of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
~	Physician		Immediate Cause (Final disease or condition	Gas	trointes	stinal	Bleed	dina						Onset and Death 4-5 days
1	/Medical		resulting in death)		o (or as a conseq		<u>Dicc.</u>	A1119						
	Examiner		Sequentially list conditions	b. Asp	iration	Pneumo	nia							3-4 days
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uance of):								
X	ecute ind trans	E a	that initiated events	0.	piratory		re							1-2 days
8760,-	e ex zian a urial-	<u> </u>	resulting in death) Last	Due to	o (or as a conseq	juence of):								
876	ficate be executed physician and s the burial-transit	dical		d										
9	ing p	Med	IF FEMALE:											
Box	death certifi e attending I d for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2  Feta		] Ectopic p	regnancy				2	23d. Date of de	
0	0 0 0	Sici	1 ☐ Yes 2 ☐ No	4 □ Pre 9 □ Uni	gnant at time of one	death 5□	Other (s)	pecify)					Month	Day Year
<u>Ч</u>	at the ded by the etached	Physician/Me	9 🖾 Unknown											
s,	The law requires that the ste has been signed by thoage 2 should be detached.	þ	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the ur	iderlying o	ause give	n in Part I.					the cause of death?
orc	pluo ould	ted	Dementia								1 🗆 \	/es 2[	_ No 3 _ Pi	robably 4 🔀 Unknown
Ö	law r as be 2 sh	Completed	<u>Hypertension</u>								24a. Was		24b. Were au	topsy findings available completion of cause of
<u> </u>		ĕ									perfo	rmed?	l death?	2 🖾 No
Vital Records,	sician: The law certificate has l irector, page 2 s	Be (	25. Was case referred to medica examiner?	No.					26. Place	of Death	(Check only o			
> <del>-</del>	Physic this co		1 ☐ Yes 2 反 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 🗆 D0	Othe	r: 4 □ Nu	ırsing Ho	me 5 ☐ Resid	dence 6	Other (Spe	Assisted cify) Living
Division of	ding Ph h. After th funeral	Ë	27. Manner of Death 1 X Natural 5 ☐ Pendir		e of Injury nth, Day, Year)	28b. Time of Injury	2	28c. Injury Work	at	1	28d. Describe h	now injury	occurred	
0	tendil Jeath. tor: A the fu	äį	2 Accident investi	gation	,,,,	, , , , ,	М		es 2 □I	No				
<u>&gt;</u>	er de recto	ij⊟	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained   28e. Plac	e of Injury - At he	ome, farm, stre	et, factory	, office		1	28f. Location (S	Street and	d Number or Ru	ural Route Number,
Ξ	tal o	Certification: To			9, (-, -, -, -, -, -, -, -, -, -, -, -, -, -	**					ony or row	m, Diate,		
	. Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifics etely filled in by the funeral director, p		29a. Certifier 1 ☐ Certifyia (Check only 2 ☐ Medical	ng Physician: To the Examiner: On the	e best of my kno	owledge, death	occurred	at the tim	e, date an	nd place,	and due to the	cause(s)	and manner as	s stated.
	To the Hospital or A within 24 hours after To the Funeral Directory completely filled in by	Medical	Uney	and ma	nner stated.					500011				
	o di Figure	2	29b. Signature and title of certifie	r	m.			c. License					e signed (Mont	
					10			000	649	//		10	5/22/0	×009
	- 1		30. Name and address of person				Print)			7	125		5	\$ 5.
	- 3		Muhammed Abdul				iam :	Drive	, Ca	tons	ville,	MD 2	1228	
	Stat Registra		31. Date filed (Month, Day, Year)		Registrar's Signa	ature	,							
				- 2000			- 4	_						

DHMH 17 Rev 1/2001

			1 - State of Maryla Registrar		artment of F rtificate of I		lental Hyg R	eg. No 2009	34275
	Physic /Medi		Decedent's Name (First, Middle, Last)     RESTITUTO MATA BATULA	N			2. Date of Deat Month OCTObe	r 20, 2009	3. Time of Death 3:30 p M
	Exami		4a. Facility Name (If not institution, give street and number) 15208 Lions Den Road		4b. City, Town, or Burtons	Location of Death		4c. County of Death	
	Funeral Director			rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 10	0 Rirth	place (State or Foreign
	aryland show	Ĺ		City, Town or Lo	cation				10d. Inside City Limits
	th the Ma or 28a-f	Director	Maryland Montgomery B  10e. Street and Number	urtonsv	ille   10f. Zip Code		1	Og. Citizen of What Cou	1 ☐ Yes 2 ☐ No XX ntry?
	ath with	ralD	15208 Lions Den Road		20866			Philippines	
920	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ont, the Medical Exaction must be redified at	by Funeral	11. Marital Status  1 Never Married  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:	U.S. 13. \	Was Decedent of H If Yes, specify Cuba 1 □Yes ※XXNo	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Baltimore, Maryland 21215-0036	be filed within 72 hours Ital Hygiene. d other than "natural", event, Irel "cdiral Ext	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give life. L		ation during most of worki f)	ng	16b. Kind of Business/Ir	dustry
d 21	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	e Col	17. Father's Name (First, Middle, Last)	Teach	ner / Sup	ervisor  18. Mother's Name	(First, Middle, M	Education Maiden Surname)	
ylan	Mental Mental arked c	To Be	Miguel Batulan			Andrea M			
Mary	d 2 g th an	ľ	19a. Informant's Name/Relationship (Type. Print)  Josephine Dario / daughter					, City or Town, State, Zi	o Code)
re,	s 1 and 2 of Health Item 27 I other tra		20a. Method of Disposition 20b		B Lions D sition (Name of natory or other place			ville, MD 20c. Location - City or To	20866 own, State
timo	Page Iment cant: If lant: If jury or		1 Manual 2 Cremation 3 Chemioval from State	Jnion Ce		1	4/2009 E	Burtonsville	e, MD
Bal	permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other <u>once</u> .		21. Signature of Funeral Service Licensee / M0 (	)770 21 3	Name and Address Donaldson 313 Talbo	ss of Facility Funeral tt Avenue	Home, P. Laurel	A. , Maryland	20707
			23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			g, such as cardiac (	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Cancer of the condition resulting in death)  Due to (or as a conse		èУ				
T	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Renal Fa						
W	uted d	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	quence of):					
68760,	ificate be executed g physician and is the burial-transit	edical Exa	resulting in death) Last  C	quence of):					
O. Box	death cert e attending d for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  23c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time o 9   Unknown	tal death 3 □	Ectopic pregnancy	/		23d. Date of deliv	ery Day Year
ords, P.	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not re	sulting in the un	nderlying cause give	en in Part I.		pacco use contribute to t	
Division of Vital Records,		Completed					24a. Was ar autops perform	y prior to co ned? death?	ppsy findings available impletion of cause of
Vita	Physician: The this certificate hard director, page	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2XXIII Hospital: 1 ☐ Inpatient 25	7500	• 3 DOA Othe	26. Place of Death			
ion of	Attending Phys ir death. ector: After this by the funeral dii	ation: To	27. Manner of Death  1 Inpatient 2 [  28a. Date of Injury (Month, Day, Year)  2 Accident Investigation	28b. Time of Injury	28c. Injury Work	4   Nursing Hor		nce 6 ☐ Other (Speci w injury occurred	(fy)
Divis	i Pire	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	cify)			City or Town		
1	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	lowledge, death nation and/or inv	occurred at the tin restigation, in my op	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as a ate and place, and due to	stated. the cause(s)
ツ	To t To t	Σ	29b. Signature and the of certifier	in	29c. License		761 i	ed. Date signed (Month,	Day, Year)
_			30. Name and address of person who completed cause of death (lte Abdul Munin, M.D. 8379 Cherry		Print) Laurel,	Marland	20707		- ]
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Sign	A. A.	and				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death  25a. Part 1. Enter the disease, or conditions cardiacor respiratory arrest, interval Between Onset and Death  25a. Bay 1. Enter the disease, or conditions cardiacor respiratory arrest, interval Between Onset and Death  25a. Bay 1. Enter the disease, or conditions cardiacor re
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S. Social Security Number  Director
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Top   State   Doc City Town or Location   Doc City Town
Andrew Joseph Piscotty Mary Christine Bochnick  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20a. Method of Disposition  1 Xi Burial 2 Colorentation 3 Removal from State  4 Donation 5 Dother (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Leonard J. Ruck, Inc.  5305 Harford Road, Baltimore, MD 21214  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Oriset and Death  1 Xi Burial 2 Colorentation (Plant Route Number, City or Town, State, Zip Code)  21c. Signature of Funeral Service Licensee  22a. Name and Address of Facility Leonard J. Ruck, Inc.  5305 Harford Road, Baltimore, MD 21214  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Oriset and Death  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Oriset and Death  25a. Part 2 Colorentation (Plant Route Number, City or Town, State, Zip Code)  25a. Plant Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Numbe
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Due to (or as a consequence of):    Columbia
S C O O O O O O O O O O O O O O O O O O
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Lectopic pregnancy  23d. Date of delivery
23d. Date of delivery    Control of the past 12 months?   1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery
1   Yes 2   No 9   Unknown   1   Pregnant at time of death   5   Other (specify)
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  Chamic Read Failure DM: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
a) 9 & Shaper Read Failure DM. Pressania
Chronic Renal Failure, DM, Pneumoria 1 yes 2 M6 3 Probably 4 Unknown
O s d to C C C C C C C C C C C C C C C C C C
g d g g g g g g g g g g g g g g g g g g
25. Was case referred to medical examiner?  1   Yes   2   No   Nursing Home   5   Residence   6   Other (Specify)
7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
27. Manner of Death   27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   28d. Describe how injury oc
27. Manner of Death   Value   Specific   Spe
in signature of the state of th
State   Stat
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
Machealle Stanuson CRUP MIN R171944 10/26/2009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michealle G. Hardson CKNP B832 Walthor Blvd, Parkvillo, MD 2/234  State 31. Date filed (Month, Day, Year)  25. Begistrar's Signature
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar 0CT 2.7 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2009 2. Date of Death Month Day Year

10

0609

2009

Physician /Medical Examiner

alter

Brooks

4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death of Maryland Medical Center *Aniversity* Baltimore N/A 8. Date of Birth (Month, Day, Year) March 27,1991 5. Social Security Numb If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Hours Min. 18 219-31-2775 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrem any injury or other traumatic event, the Menteral Englishment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2X No MD Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 West Hilltop Road 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married 1 ∐Yes 2 XNo Specify White Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Brian Brooks Sr. Denise Marie Waters ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Walter B. Brooks Sr/Father 205 West Hilltop Road Brooklyn, Maryland 21225 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) October 27. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Brooklyn Park, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** *septic* Shock disease or condition resulting in death) /Medical as a consequence of): Examiner Distress Syndrome Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, -N1 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 X Natural

2 Accident 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A

oletely filled in by the fo death. 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) m w 10/21/2009 DUO 31590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 5 GREEN? 32. Registrar's

State Registrar

			ameno 1 - For State Registrar	state of	Maryland beb	artment of tertificate of			jiene leg. No. 20	09 34	278
	Physici /Medi		1. Decedent's Name (First, Middle, L HERMAN	J.	BRINKMANN		129	2. Date of Dea Month OCTOBE	R 25,20	(ear 0 9 6:2	
	Examir		4a. Facility Name (If not institution, g. ST. JOHN NEUM	ANN RES	IDENCE	TIMON:				TIMORE	or Foreign
	Funeral Director			Sex 1MM 2□F	7. Age (In yrs. last birthday 81 Yrs.	Months Days	Hours Min.		,1928 F	9. Birthplace (State Country) PENNSYLV	ANIA
	e Maryland ia-f show	Director	10a. State 10b. County  MD BAL	rimore	10c. City, Town or L	ocation NIUM				10d. Inside C	City Limits
	ath with the 23a or 28	ral Dire	10e. Street and Number 2300 DULANEY	_			1093			.A.	
-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be rediffed at	To Be Completed by Funeral	11. Marital Status  1 ★ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  15. Decedent's B	Armed Ford 1 <b>X</b> es : If Yes, Give Year or Da	2 No 1966 – 86 tes: 1968 – 88	Was Decedent of H If Yes, specify Cub 1 □Yes 2 X No edent's Usual Occup	Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, White, etc.  WHITE  ness/Industry	
F : Maryland 01015_0036	ed within 72 ygiene. er than "na t, it e Medic		(Specify only highest g Elementary/Secondary (0-12)	College (1- 5 +	(Giv	e kind of work done DO NOT use retire PRIES	during most of wo d) $\Gamma$		CATHOLI	C CHURC	H
z. Wand	ould be file Mental H Marked oth			KMANN			HE		IDMEIER	<u> </u>	
Baltimore, Mar	Pages 1 and 2 sh nent of Health and ant: If item 27 is n ary or other traun		19a. Informant's Name/Relationship REV • GERARD SZ  20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	YMKOWIA	K/PASTOR  20b. Place of Disposeratery, createry, osition (Name of ematory or other pla	LANEY V.	ALLEY R	OAD, TIM 20c. Location - C	IONIUM, Mility or Town, State		
Raltim	permit. Pages Department of Important: If is any Injury or once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	ify)	HOLY RE			Y 10/30 G STREE		HOME , MD. 2	IA, PA 1224
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a	used the death. Do not end that the death of		ng, such as cardia			Approxima Interval Be Onset and	etween
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	death certifi e attending I d for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	ant at time of death 5	□ Ectopic pregnand □ Other (specify) _	су		23d. Date Mont	of delivery th Day	Year
ק מ	quires that n signed build be deta	d by Ph	Part II. Other significant conditions	i, 400021 20	ath but not resulting in the	underlying cause giv	ven in Part I.			oute to the cause of	
Vital Records,	The law requires that the cate has been signed by the page 2 should be detached.	Completed	Jisn2/	1/212				24a. Was a autop perfor 1 □ Yes	sy pr poed? de	ere autopsy findings ior to completion of ath? ⊒Yes 2 □No	available cause of
F Vits	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 ☐ ER/Outpati	ent 3 DOA Oth	201:	ath (Check only of		(Specify)	
ion of	ding I	Certification: To	27. Manner of Death  1 为 Matural 5 ☐ Pending 2 ☐ Accident investigation	on	h, <i>Day, Year)</i> Injury	M 1 🗆	ry at rk? ]Yes 2 □ No	28d. Describe h	ow injury occurred	d	
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of buildin	of Injury - At home, farm, s g, etc. <i>(Specify)</i>			City or Tow	n, State)	r or Rural Route Nui	mber,
3	the Hospital hin 24 hours a the Funeral mpletely filled	Medical			best of my knowledge, dea usis of examination and/or er stated.						(s)
	To the company	Σ	29b. Signature and the obcertifier	rele 1	20	29c. Licens	se number			(Month, Day, Year) ER 26, 200	ng
	HV		30. Name and address of person who		e of death (Item 23a) (Type					20, 200	
	Sta Regist		31. Date filed (Month, Day, Year)		egistrar's Signature	arke					

6:25 P.M.

OCTOBER 25, 2009

HERMAN BRINKMAN

Division of Vital Records, P.O. Box 68760,

		Please Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and	Mental Hygier	ne
		1 - State Certificate of Death	No. 2009 34279	
Physicia	an	1. Decedent's Name (First, Middle, Last)		Day Year
/Medic		Donald Henry Berwager	Oct 7	4 2009 Z&P
Examin	er	4a. Facility Name (If not institution, give street and number)  Carroll Hospice Dove House  4b. City, Town, or Location of Deat  Westminster	r	4c. County of Death  Carroll
Funeral Director		5. Social Security Number 218-28-1085 6. Sex 1 Months Days Hours Min.	9. Birthplace (State or Foreign Country) Maryland	
Maryland a-f show	ctor	Usual Residence of Decedent    10a. State	r	10d. Inside City Limits 1 □Yes X□No
h with the	Funeral Director	10e. Street and Number 10f. Zip Code 2702 Sykesville Rd. 2115		Citizen of What Country? USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	þ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
within 72 hou jiene. r than "natur.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Engineer	orking	Kind of Business/Industry  Transportation
ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle, Maid Blauvelt	len Surname)
nd 2 shoul lith and M 27 is mar r traumat	Ţ	19a. Informant's Name/Relationship (Type. Print)  Jessie M. Berwager-wife  19b. Mailing Address (Street and Number or Fig. 2702 Sykesville Ro		
Pages 1 ar nent of Hea ant: If item ury or othe		20a. Method of Disposition  1  Burial 2  remation 3  Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Trinity Luth Cem. 10-		Location - City or Town, State
permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee		Funeral Home
Physician /Medical Examiner	by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ac or respiratory arrest,	Approximate Interval Between Onset and Death
ate be executed hysician and he burial-transit				
Attending Physician: The law requires that the death certificate be r death. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year
n requires that the d been signed by the should be detached	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
The law rec cate has bee page 2 shou	Completed	Diabeter Mællitus II	24a. Was an autopsy performed 1 □Yes 2 D	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
ysician: is certific director,	Be	25. Was case referred to medical examiner?	eath <i>(Check only one)</i> Home 5 □ Residence	e 6 Komer (Specify)
ending Ph sath. or: After th he funeral	Certification: To	27. Manner of Death  12 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury 28b. Time of Injury 4 Work?  Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how it	njury occurred the area of
tal or Attres after de al Directo	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	
To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	curred at the time, date	and place, and due to the cause(s)
To with con	M	29b. Signature and title of certifier  29c. License number  DODO 070	29d.	Date signed (Month, Day, Year)
CA	<	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	d. Com	on Sudge Ma 22
Sta Registr	ar	OCT 27 2009 Live S. Barker		
HMH 17 Rev 1/20	JUT	ORIGINAL		

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State of Maryla State Registrar  1. Decedent's Name (First, Middle, Last)		tificate of Death	2. Date of D	Reg. No. 200	9 3428
Physicia /Medic		Adrienne Ann Breighne	r		Month	3-2009 Yea	5:30A
Examin	er	4a. Facility Name (If not institution, give street and number)  23 Kwanzan St.		4b. City, Town, or Location of Taneytown	Death	4c. County of De	
Funeral Director		212-70-1352 1□M 2対F 56	rs. last birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of B (Month, E) 8. 6-2-1		Birthplace (State or Fore Country) ryland
Maryland a-f show	ctor	Usual Residence of Decedent  10a State Carroll  10c. 0	City, Town or Loc	Taneyto	√n		10d. Inside City Limi
h with the	al Director	10e. Street and Number 23 Kwanzan St.		10f. Zip Code 21 787		10g. Citizen of What o	Country?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Medical Expriner must be notified at	by Funeral	11. Marital Status  1 ▼Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 ▼Yes 2 ▼ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origi Yes, specify Cuban, Mexican, □Yes 2 HNo Specify:	n? (Specify Yes or N Puerto Rican, etc.)		merican Indian, nite, etc. white
thin 72 houe. e. an "natura Medical E	Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give I	lent's Usual Occupation kind of work done during most of NOT use retired)	of working	16b. Kind of Busines	
e filed wil	Be Con	1 2 17. Father's Name (First, Middle, Last)	A	ssembler 18. Mother's	s Name (First, Middle	ARC of C	arroll Co
es 1 and 2 should be fil of Health and Mental H fitem 27 is marked ott r other traumatic even	ဥ	Francis Joseph Breigh:  19a. Informant's Name/Relationship (Type. Print)	1	Je g Address (Street and Number	nnie Mat		Zin Code)
and 2 sealth an 27 ls i		Carole J. Kraus-sister		Grant Dr. Ge			
Pages 1 and the part of the part; if item and, ary or other		AND BUTTAL 2 LI Cremation 3 Li Removal from State		sition (Name of latory or other place)  Valley Mem.	Date 10-27-09	20c. Location - City o	
permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee	22.	Name and Address of Facility 254 E. Main	Fletcher	Funeral	Home MD 21157
rificate be executed  ag physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consecutive conditions).		er's Deme	~0		
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of o	ielivery Day Year
uires that signed b	۵	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause given in Part I.		tobacco use contribute	to the cause of death?
Attending Physician: The law requires that the death cerdeath. sctor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	Completed				perf	opsy prior t formed? death	autopsy findings availa o completion of cause ? es 2 □No
ysiclar	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	☐ ER/Outpatient	Other	f Death <i>(Check only</i> ing Home 5 ☑ Res	one) sidence 6 ☐ Other (Si	pecify)
ath. r: After th	Certification: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?			
tal or Att. rs after de al Directo	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	own, State)	and Number or Rural Route Number, te)			
<u>re</u> ≥ 2 <u>re</u>	Medical	29a. Certifier  (Check only one)  1	nowledge, death Ination and/or inv	occurred at the time, date and restigation, in my opinion, death	place, and due to th occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
n 24 hd n 24 hd ne Fun oletely	8			29c. License number		29d. Date signed (Mo	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and title of certifier		D436	43		nth, Day, Year) LL • 09

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 2009 3:05 A™ Jo Beck Mary Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 💢 F Maryland Director 215-30-6230 76 Usual Residence of Decedent n of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 21286 U.S.A. 262 E. Susquehanna Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐XNo 3 Widowed 4 X Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education <u>School Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marv Barriger Walter James Sackett permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 909 Coteswood Circle Cockeysville, Maryland 21030 Lynne Rothermel Daughter altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Dulaney Valley Memorial Gardens Burial 2 Cremation 3 Removal from State 10-26-2009 Timonium Signatur 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Maryland 21204 Towson, icker! <u> 1050 York Road</u> 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ orec disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E. ter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗓 No 26. Place of Death (Check only one) ompleted filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate; After work' 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 26810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	-	Certificate of			Reg. No. 200	34282		
	Physicia	n/	1. Decedent's Name (First, Middle,	Last) +lejewski				2. Date of Dea		3. Time of Death		
	Medio Examin		4a. Facility Name (if not institution,	give street and number)	``	4b. City, Town,	or Location of Death		4c. County of Dea	ith ,		
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birtho	(av) If Under 1 Year	If Under 24 Hrs.	8, Date of Birt	1	thplace (State or Foreign		
	Director		219-32-7994	1 <b>X</b> M 2□F	72 Yr	Months Days	Hours Min.	Aug. 29	, 1937 Ma	ryland		
	show dat	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Baltimore City								10d. Inside City Limits		
	r 28a-1	Director	Md.		ватс	10f. Zip Code			10g. Citizen of What C	Yes 2 No		
	with the s 23a o	Funeral	634 Umbra Sti	eet		212	24		U.S.A.	oundy:		
<b>'</b>	or item		11. Marital Status  1  Never Married 2  Married 2	12. Was Decedent E Armed Forces? ed 1 X Yes 2		13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puert	pecify Yes or No- po Rican, etc.)	14. Race - Am Black, Whi			
903	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.V	ietnam	1 ☐ Yes 2 🛛 N			Specify: W	hite		
215-	י 72 הסו <b>an "nat</b> Medica	mple	15. Deceden (Specify only highes Elementary/Seconday (0-12)		(0	lecedent's Usual Occu Give kind of work done fe. DO NOT use retired	during most of wor	king	16b. Kind of Business	s Industry		
121	d withir lygiene ther than nt, the	வ	11th			chinist	T		Western	Electric (unk)		
lanc	ould be filed d Mental Hy marked oth matic event		17. Father's Name (First, Middle, La John Betle				Kathe		Maiden Surname)	(dirk)		
Baltimore, Maryland 21215-0036	ge 1 and 2 should bo it of Health and Mer it item 27 is marke or other traumatic		19a. Informant's Name/Relationsh Marcelle Bet						r, City or Town, State, Z			
re, I	of Healt fitem 2 rother		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla	1004	ober	20c. Location - City o			
timo	Par ant ury		1 Burial 2 Cremation 4 Donation 5 Other (S)	pecify)	Bayvie	ew Cremat	ory 26,	2009		e,Maryland al Home,PA		
Ba	permit. Departi Import any inji		21. Signature of Funeral Service Li	ensee		22. Name and Addr 1201 Dun	dalk Av	enue Ba	altimore,	Md.21222		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
Ē	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Due to (or a consequence of):									
	Examiner	Į.	Sequentially list conditions,	b. hes	water	Faclure				days		
	uted d ansit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.									
	icate be executed physician and is the burial-transit		resulting in death) Last  Due to (or as a consequence of):									
3760	ficate b g physi as the b	Medical	IS SERVICE	d								
Box 68	death certif he attending ed for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death	3  Ectopic pregnat	псу		23d. Date of d	elivery Day Year		
B	the dea by the a ached f	hysic	1 ☐ Yes 2 X No 9 ☐ Unknown	9 Unknown	t time of death	- Other (specify)						
s, P.O.	es that signed I be det	Pair II. Other significant conditions contributing to death out not resulting in the underlying cause given in race.								o the cause of death?  Probably 4   Unknown		
ords	w requires been standord	Completed	24a. Was an 24b. Werd							utopsy findings available		
Division of Vital Records,	The lar	Com				=		autop perfo 1 🗆 Yes	rmed? death?	completion of cause of		
Vital	s certifi director	Certificate: To Be	25. Was case referred to medical examiner?  1  Yes 2  Yo	Hospital:	ent 2 🗆 ER/Outp	I <sub>O</sub> +	Place of Death (Che		lence 6 ther (Spe	city KLOSNICE -		
Jo L	ing Phy I. Vfter thi uneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju	ry 28b. Tin	ne of 28c. Inju	ıry at rk?	T	ow injury occurred			
isior	Attend or death octor: / by the f		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined Investigation M 1 Yes 2 No 286. Location (Street and Number or Rural Route Number) 287. Location (Street and Number or Rural Route Number)							ural Route Number,		
Οİ	oital or ours afte eral Dire			building, etc		-11		City or Tow				
ī	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To thin 24 hours after death.  To the Funest all pirector. After this certificate has been signed by the attending from the Funest Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination and/or i	nvestigation, in my opir	nion, death occurred	at the time, date a	nd place, and due to the	cause(s) and manner stated.		
1	North Com		29b. Signature and title of certifler	11/21 w	)	29c. Licen	se number	186	29d. Date signed (Month, Day, Year)  OA 24, 200 9  Baltmer, MD 21204			
			30. Name and address of person v	ho completed cause of d		pe, Print)		2) 0	11	1,000		
	C+c-	0	31. Date filed (Month, Day, Year)	284 SSS	S West	- TOWSOV	How &	51 rd, 1	baltimere	M 21204		
	Stat Registra			100 /	6	6-11						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death Month Physician en 540 a M ctober /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of D pi tal timore If Under 24 Hrs.( Date of Birth Month, Day, 7. Age ( wrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Hours Mir Verth (Arclin Director Usual Residence of Decedent 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Town or Location 10d. Inside City Limits Director 1 kes 2 No more 10f. Zip Code 10g. Citizen of What Coupt by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc., 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. PO NOT, use retired) ry (0-12) College (1-4or 5+) and 2 should be filed tealth and Mental Hygi Be Name (First permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 4 Domition 5 ☐ Other (Specify) Sonature of Funeral Service Licensee Part 1. Enter be disease, or complications that caused the death. shock, or hand failure. List only one cause an each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death ģ 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) o the detached ₫. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a Was an director, page 2: certificate of Vital 1 ☐ Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. investigation death 2 Accident 1 ☐ Yes filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

and manner stated. (Check only one) the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varish

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year!

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34284 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Howard Carney October 2009 8:13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Director 219-68-8783 54 Maryland Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 U.S.A. 1000 Rohe Farm Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 1 X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maritime Labor/Shipping 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Gibson Barbara Tiee Carney Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Jean Moore/ Sister 1000 Rohe Farm Lane, Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Anatomy Gifts Registry 20c. Location - City or Town, State Date 1 
Burial 2 Cremation 3 Removal from State 10/27/2009 Hanover, Maryland 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Anatomy Gifts Registry >0 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician; The After this certificate 1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Cher (Specify) 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34285 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 AM **Physician** 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10-13-1959 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 1 M 2 □ F 215-78-6136 50 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other thaumalt event, Ite Medical Exert. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Yos 2 □ No **Funeral Director** MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2511 Hollins Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status was Decedent Evi Armed Forces? 1√Yes 2 □ No If Yes, Give Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker Joe Corbi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Chandler sr. Christine Johnson ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other traul once. Christine Chandler/Mother <u> 2511 Hollins Street, Baltimore, MD 21223</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-2-09 Owings Mills, MD Garrison Forest Veterans 22. Name and Address of Facility Wile Funeral inne P.A. of Balto. Co. 21. Signa are of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Sty hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and enterly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 🛠 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 🗌 No 3 Probably **₩**nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops) perform 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To Inpatient 27 Manner of Peath ate of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature a 29c, License number 29d. Date signed (Month, Day, Year)

State

State Registrar 30. Name and address

Date files (Month, Day, Year)

person who

DHMH 17 Rev 1/2001

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 9 34286 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 200<sup>9</sup> ar **Physician** 26 6:50 A. M CAMAK MARGARET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTO CATONSVILLE MANORCARE WOODBRIDGE VALLEY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1□M **X**F 103 220-30-3292 NC Director 08/03/1906 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show treumatic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number IISA 21218 601 WYANOKE AVENUE 230 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Specify: BLACK 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEALTH PRACTICAL NURSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental H REBECCA SNOW **EDWARD** TABRON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1353 WINSTON AVENUE, BALTO., MD 21239 Health item 27 I REV. RICHARD TABRON/NEPHEW other Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent: If ite eny injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 10/31/09 KING MEM. PARK ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE MYPERTENSIVE Physician /Medical Due to (or as a consequence of): DAY WARM MYROTEL & MENTAL Examiner Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 No 3 Probably 4 □Unknown ACUTE RENAL FAILURE 1 🗌 Yes Completed MY 6 CA-RDIAL INFARUTION 24a. Was an autopsy performed? 1 ☐ Yes 2. No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No TIBIA - FIBULA FRACTURE 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1⊠Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation FALL IN THE BATHROOM 1 Natural 07-31-2009 4:00 PM death. 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1525 N. RBLLING P. CATONS VILLE, MD 21228 6 Could not be 3 🗌 Suicide determined 4 - Homicide MANUR CARE NURSING HOME Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Division of Vital Records, Hospitel or Attending Physician: e Funerel within 2 the

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS CENTER DRIVE UMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DUV59107

REISTERSTOWN

29d. Date signed (Month, Day, Year)

10-26-2009

Registrar DHMH 17 Rev 1/2001

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State

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:50 AM **Physician** Hilda 22,2009 OCTOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Center Johns Hopkins Bayview Care Baltimore Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2XXF 233-48-5901 Pennsylvania May 10, 1931 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Experient must be notified at 1 ☐ Yes 2/XNo Director MD Anne Arundel Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 451 Yellow Spring S 20724 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar John Sanders Genie E. Nestor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1681 Village Green Drive, Woodbine, MD 21797 Phillip Czyryca/ Son Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | 10/27/2009 | Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 2 M01103 i 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Lause (Final
Chronic Obstructive Pulmonary Diseases are carding.) Approximate Interval Between Onset and Death Diseuse Pulmonar Thronic **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ Embolism 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Fibrillation 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 No sleep aphea 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P s after death. I Director; After I 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/22/09 P04383 5505 HOPKINS BAYVIEW CIRCLE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. B Greenough I MO BALTIHORE, HD 2/2 32. Registrar's Signature 31. Date filed (Month,-Day, Year) State Jacks Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OUISE /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 830 W. **Examiner** 40th Street N/A 21911 Baltmore Mid E 8. Date of Birth (Month, Day, Year, Aug 22, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Days Hours **Funeral** Months 1 □ M 2 🖫 Maryland 95 214-01-8041 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show 1X Yes 2 No 28a-f sh notified Director N/A Baltimore City Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or **USA** 21211 830 West 40th Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 7 is marked other than "natural", or items traumatic event, the Medical Examiner man 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White Baltimore, Maryland 21215-0036 9 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant; If item 27 is marked oth Be Louise Randall Robert Lee Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important; If item 27 is any injury or other trauonce. 434 Loblolly Way, Grasonville, Maryland 21638 Robert F. Cockey 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Reisterstown, Maryland 10/28/2009 All Saints Ch Cem 4 □ Donation 5 □ Other (Specify) 21. Signature of Sun (c) Seruce (c) MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEMENTIA ENDSTAGE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Me 24a. Was an autopsy performed? 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 Tyes 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After t 5 Pending investigation Certification: 1 ☐ Yes 2 ☐ No death. 2 Accident ours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D35102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHarles Street Baltimon Maryland 0 5901 Novih Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 **Physician** John Edward 0345 A M Cary 2005 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Burnie (enter Washington Medical Glen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct. 15, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months 78 217-24-8983 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan 28a-f show Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ither traumatic event, the Modical Examinal must be notified at 1 ☐ Yes 2 ∑ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 249 Cross Creek Drive 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Baptist Cary Mary Cecilia Carrol1 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Heath Important: If item 27 any injury or other troonce. Mrs Cynthia Frank /Daughter 350 Honeylocust Court Bel Air Maryland 21015 Date 30 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets Cem. 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses 10/35 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonny OBSTRUCTURE **Physician** HADNIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami sician and burial-trans Division of Vital Records, P.O. Box 68760, ベ Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Oder 25,2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) WAILINGTON Medical Center

Registrar DHMH 17 Rev 1/2001

State

BATTIMORE

32. Registrar's Signature

Mp.

TANC! I

31. Date filed (Month, Day, Year)

		1	For State Registrar	State of Marylan	•	artment of He tificate of De		entai mygien Reg. N	E 0 0	9 34290				
	Physicia	n/	1. Decedent's Name (First, Middle, Last	•				2. Date of Death Month	Day Year	3. Time of Death				
	Medic Examin	al .	4a. Facility Name (if not institution, give	etreet and number)		4b. City, Town, or L	ocation of Death	10/24	c. County of Death	7/33 PM				
-	LAGIIIII		Gilchnist H	USPICE		7000	more		Balto					
	Funeral Director		5. Social Security Number 6. Se 213-07-6312	×		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Year)	915 9. Birt	hplace (State or Foreign untry) MD				
	and show Lat	. h	Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo					10d. Inside City Limits				
	Maryla 28a-f	irect		imore	Balt	imore		10- (	Citizen of What Co	1 Yes 2 No				
	with the	Funeral Director	10e. Street and Number 525 48th Str	eet			1224	10g. C	USA	unity				
980	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show maric event, the Medical Examiner must be notified at.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 <b>X</b> Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of Hist If Yes, specify Cuban 1 ☐ Yes 2 🛣 No		ify Yes or No- lican, etc.)	Yes or Non, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White					
Maryland 21215-0036	nin 72 hou ne. than "natu e Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occupat kind of work done du O NOT use retired) Ervisor	tion Iring most of workin	g S	16b. Kind of Business Industry   Sparrows Poir   Shipyard					
d 2	iled with I Hygien other ti rent, the	Be	12th 17. Father's Name (First, Middle, Last)		n Surname)									
ylan	should be file and Mental F is marked o raumatic eve	욘	Charles W. C				<u>_</u>	et Hofhe						
	12 shullth an 27 is r trau		19a. Informant's Name/Relationship (Ty Maurice L. Co		19b. Mailii	ng Address (Street ar 30 Gore	nd Number or Rural Mill Roa	Route Number, City ad Freel	and MD	21053				
Baltimore,	Page nent o		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.	Removal from State	cemetery, crei	osition (Name of matory or other place wn Cemet	) ! .	20c. 28/09 Ba	Location - City or ltimore					
Balt	permit.   Departn Importa any inju		21. Signal re Juner Service Lices	e Cruelly &		2. Name and Address								
	Pnysician/	200	23a. Part 1. Enter the disease becomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Approximate Interval Betwee Onset and Dead of the Control o											
	Medical Examiner		resulting in death)	a. Due to (or as a conseq	u-nce of):	0	,000							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	b. Due to (or as a consequence of):									
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last											
200	ate be e ohysicia the buri	edical	•	d										
Box 687	ath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregnation 1  Live Birth 2 Fet Fet   4  Pregnant at time of   9  Unknown	1		23d. Date of de Month	elivery Day Year						
s, P.O.	requires that the derbeen signed by the should be detached		Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause give	en in Part I.			o the cause of death? Probably 4 M Unknown				
Division of Vital Records, P.O.	The law requirate has been bage 2 should	Completed by	Hypertension					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of				
ita	ician: certifica	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		_ Othe	ce of Death (Check			in KOSPICE				
n of V	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Injury works	at 2	me 5 Residence		Carry) CC 3 FTC C				
ivisio	or Atter after dea Director in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st fy)	reet, factory, office		28f. Location (Street City or Town, Sta		ural Route Number,				
۵	To the Hospital within 24 hours a To the Funeral Completed filled	Medical (	(Check 2 Medical Evam	sician: To the best of my know iner: On the basis of examinationse Practioner: To the best of n	on and/or inve	stigation, in my opinio	n. death occurred at	the time, date and pla	ace, and due to the	cause(s) and manner stated.				
	To the within To the comple	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practioner: To the best of h	iy kilowledge,	29c. License	number	29d.	Date signed (Mont					
			30. Name and address of person who	completed cause of doath (Ita	m 23a) (Type	Print)	8286	,	10/25/	2007				
	131		Natalle E We	St, MD 555		est Tons	entenn	Blid, 1	saltin	re, UD 21204				
	Sta Registr		31. Date filed (Month, Day, Year) <b>OCT 6.7 2009</b>	32. Registrar's Sign	ature	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08248 State of Maryland / Department of Health and Mental Hygiene Jared Todd Church 2009 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 23, 2009 2155 hrs Medical Examiner JARED TODD CHURCH 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Harford **Bel Air** NB 543 Goat Hill Rd./2605 Creswell Rd. If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Country) Director 34 Vrs 1 XM 2 Maryland 220-72-8410 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show notified at once. Bel Air Maryland Harford hours after death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21014 102 C Seevue Ct. 23a 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) must be Armed Forces? 2 v Married 1 Never Married 2 X No Yes Specify: White Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced narked other than "natural", event, the Medical Examiner δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Retail College (1-4 or 5+) Flementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Distribution Center Baltimore, MD 21215-0036 Operational Support Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Madeline VanRossum Lester Lee Church 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 102 C Seevue Court, Bel Air, Maryland 21014 27 is Aimee Church / Wife 20c. Location - City or Town, State item ? 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 Important: injury or oth Service Corp. 10-26-09 Towson, Maryland Donation 5 Other Specify: McConas Funeral Home, P.A. 21. Signature of Funeral Service Licens Maryland 21014 Broadway St. Bel Air Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED DIVISION OF VITAL RECORDS, P.O. Box 68760, in the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE phy the b 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter the detached for ur 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26 Place of Death (Check only one) 25. Was case referred to medical æ Other<sub>4</sub> examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outnatient 3 Inpatient 2 After this 1 V Yes 28a. Date of Injury (Month, Day Year Oct 23, 2009 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Driver in an auto to auto collision Certification: 2155 hrs 1 Natural 1 Yes 2 ✔ No 5 Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the 1 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) NB 543 Goat Hill Rd./2605 Creswell Rd., Bel Air, MD (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 24, 2009

and manner stated

Assistant Medical Examiner 2. Registrar's Signature

ORIGINAL

surall in 30. Name an address of erson who completed cause of death (Item 23a)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

9 7 2009

DHMH 17 Rev 1/2001 **OCME 2006** 

le

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrate 34292 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:15 PM harles 09 10 /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Perring Parkway Parkville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State (Month, Day Year) | 1922 | Mary Land 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 💢 M 2 🗆 F Director 219-10-7827 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Evan mer must be notified at 1 ☐ Yes 2 XNo Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21220 USA items 23a 36 Ketch Cay Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ▼TYPes 2 □ No 17 Pes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify. 2 3 Widowed 4 Divorced "natural" White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Custodian 6 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental int: If item 27 is marked o Mary Elizabeth Dollenger Lawrence Williams Cornes ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 36 Ketch Cay Ct., Baltimore, Maryland 21220 Cindy Roth / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 10/23/09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the disth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fatilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION INEUMONIA /Medical Due to (or as a consequence of): Examiner ONGOSTIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ORONARY P.O. Box 68760. by Physician/Medical ATERAL CAROTIL IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, within 24 hours after death

To the Funeral Director:
completely filled in by the f

2+1

State Registrar

Medical

(Check only

29b. Signature and title of certifier

Marcia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

R087625

29d. Date signed (Month, Day, Year)

10/20/09

BALTIMORE

			For State Registrar	State of M		/ Depa	artment of F	lealth and N	Apptal Hya	_	34293			
			1. Decedent's Name (First, Midd	ile, Last)					2. Date of Deat Month		3. Time of Death			
	Physicia /Medic		Mary C	atherine	Compto	on			OCTOBE					
	Examin		4a. Facility Name (If not institution Saint Jose	on, give street and number, ph Medical		er	4b. City, Town, or	Location of Death		4c. County of Dea	ath Ltimore			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign			
	Director		216-12-9659	1□M 217 F	87	Yrs.	Months Days	Hours Min.	Sept 4,	1922 Wes	st Virginia			
	and		Usual Residence of Decedent  10a. State 10b. Count	y	10c. City,	Town or Lo	ocation				10d. Inside City Limits			
	Maryl f sho	ō	MD B	altimore	1	Baldw	in			1 □Yes 2				
:	7.28a	Director	10e. Street and Number			***	10f. Zip Code		1	0g. Citizen of What C	country?			
	h with	al D	17 Manor Kno	11 Court			21013	3		U.S.A.				
	deat	Funeral	11. Marital Status	12. Was Decedent	7	13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Wh				
0	or ite		1 Never Married 2 Ma	rried 1 Tes 2 T	X <sub>No</sub>		1 □Yes 2 □ <b>X</b> No	Specify:		Specify:	White			
3-003p	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examilian to inclifed at	ed by	3 ■Widowed 4 □ Divorce		1	16a Dece	dent's Usual Occup	ation		16h Kind of Busines	. Kind of Business/Industry			
מ	n 72 n "nat	olete	(Specify only high	nt's Education est grade completed)		(Give life.	kind of work done DO NOT use retired	during most of worl d)			•			
7	r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	C1	erk Typis	st		Shippir	ig			
and,	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle	e, Last)			-			Maiden Surname)				
<u>a</u>	uld by Menta arked atic e	70 E	John	Lombardi				Dolin	da	Rotol	0			
ם :	2 sho l and is ma rauma		19a. Informant's Name/Relation				3			r, City or Town, State	Zip Code)			
າ ຂໍ້.	and lealth im 27 her to		John R. Compt	on-son	DOL DIS				Baldwin, MD 21013  Date 20c. Location - City or Town, State					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturali", or items 23a or 28a-1 show any injury or other traumatic event, the I wife I Examinate in the I will be I once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation				osition (Name of matory or other place Vallay			Timonium,				
baltimor	if. Pa irtmei irtant injury		4 ☐ Donation 5 ☐ Other (		-	10	Valley  2. Name and Addre		27/09					
ם ם	Deps Impo		21. Signature of Furierar Service	<sup>e Licensee</sup> William	m G. Da	au I	1050 York	Ru	ck lowso wson MD	n Funeral 21204	Home, Inc.			
			23a. Part 1. Enter the disease,	or complications that cause	d the death.						Approximate Interval Between			
F	hysician	6 70	Immediate Cause (Final	st only one cause on each		1 P*-1-11	"1 IM/"NT /"				Onset and Death			
	/Medical		disease or condition resulting in death)	Cit -	s a conseque		EUMONIA				Lon VV Erop Sound \			
e <sup>c</sup>	Examiner		Sequentially list conditions	b. CHRON	IC OF	STRU	JCTIVE F	ULMONAF	RY DISE	ASE				
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseque	nce of):								
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ם.	th. After funera	tion:	27. Manner of Death  1 X Natural 5 □ Pend 2 □ Accident inves	ing 28a. Date of In (Month, D		28b. Time o Injury	Wor	ryat 1k? ]Yes 2∐No	28d. Describe h	low injury occurred				
IVISION	or Atter fter des irector in by the	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be mined 28e. Place of Ir building, e	njury - At hometc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,			
_	portal o		29a. Certifier 1 X Certify	ring Physician: To the bes	t of my know	ledge, dea	th occurred at the t	ime, date and place	and due to the	cause(s) and manner	as stated.			
:	to the Hospital or Attending Physician: The law requires that the of within 24 Hours after death.  Within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	edical	(Check dely 2 Medicone)	ring Physician: To the bes al Examiner: On the basis and manner s										
	with To t	Σ	29b. Signature and title of vertil	ier	ANA	1012	29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)			
					1		D	60005		10/24	09			
			30. Name and address of person	n who completed cause of	death (Item 2	23a) (Type,	, Print)			•				
		te	31. Date filed (Month, Day, Yea	PNL AND I MGHA	trar's Signatu		7601 09	SLER DRI	WE TOW	SON. MAR	YLAND 21204			

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:03 AM **Physician** 2009 OCTOBER 21 Joseph H. Domm /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE WASHINGTON MEDICAL BURNIE HRUNDEL GLEN If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year) Months 1**X** M 2 □ F Director March 15, 1958 Maryland 219-78-5550 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "wed call Even", and it is to be soften as a second of the control of the con 1 □Yes 2 X No Director Maryland | Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 United States 7765 Freetown Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domm, JOSEPH N/ANone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn Toomey Joseph Henry Domm, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, MD 21146 Kathy Stock / Sister 698 Benfield Blvd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 💹 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Oct. 28,2009 Catonsville, Maryland Metro Crematory 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 01360 Crain Hwy. SE; Glen Burnie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) de /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner burial-transit The law requires that the death certificate be executed aquate signed by the attending physician and deed betached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? certificate 1 ☐Yes 2 ☐No 24 1 □Yes Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 C Natural 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident completely filled in by the 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending within 24 hours a To the Funeral L the

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Suite 305 Glen Burne

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No.

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 24, 2009 **Physician** 4:40 A M Violet E. Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) 1924 Harford Forest Hill Rock Spring Village 9. Birthplace (State or Foreign Country)
Illinois If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs, last birthday, **Funeral** Hours Months Days 1 □ M 2 1 F 85 Director 234-34-7117 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show Baltimore 1 XYes 2 No Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 USA 3206 Brendan Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 🗓 No White ð Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie E. Smithers Pryor L. Shoemaker ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 Claret Drive Fallston, Md. 21047 Friend Charles J. Lutz 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-27-2009 Parkville, Md. Parkwood 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 disease 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 COther (Specify) A Gist out Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-26-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 MD 21050 State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELSON 000382 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltinere Medical Merry N/A 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2 Birthplace (State or Foreign
Country) If Under 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Year, Min. Months Days Hours Oklahoma 1969 216-06-7985 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exx., it are must be notified at once. 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Directo Anne Arundel Co. Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 7913 Stonehearth Road 21144 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ **Black** 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Industrial Laborer Air Conditioning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Ruth Richardson Nelson Davis, Jr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Phillip Richardson / Uncle 18 Windflower Dr. Newark, DE 19711 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Boone Memorial Park | 10/30/2009 | Madison, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Services, PA; 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final meureonea wech **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Tyear Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 standard autopsy performed? Ves 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1-☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific OCTOBER 22, 2009 0 pleted cause of death (Item 23a) (Type, Print) and address of person baltimore, MP 21201 ZHUKN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21, 2009 October Guadalupe Espinosa 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10003 Fernwood Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F Director 201-36-2948 Ecuador 66 December 31, 1942 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10b County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, it a Medical Examirat must be note. 20817 10003 Fernwood Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 √ Yes 2 No Specify: Ecuadorian þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Margarita Guarderas ဥ Neptali Leon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramiro Espinosa/Husband 10003 Fernwood Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 24. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Kobert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01548 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check onfy one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

State Registrar

Frederick Barr, M.D. 31. Date filed (Month, Day, Year) 0009

29b. Signature and title of certifier.

29d. Date signed (Month, Day, Year)

D22775

29c. License number

October 21, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Avenue, Suite 1300, Chevy Chase, MD 20815

32. Registrar's Signature

		For State Registrar	State of	Maryland /	Depa Cer	artment of rtificate o	Health f Death	and Me	ntal Hy	giene Reg. No.	200	9 (	34298		
		Decedent's Name (First, Middle, I	.ast)					2	. Date of Dea	ath			Time of Death		
Physicia /Medic		EVA WILLIE EDW	ARDS					c	Month CTOBE	R 23	2009		1:00 PM		
Examin		4a. Facility Name (If not institution, g	rive street and numb	per)		4b. City, Town,	or Location	of Death			County of Dea				
		FOREST HILL HEAD	LTH & REHA	ABILITAT	ION	FOREST					HARFOF	RD.			
Funeral			Sex 7. 1 □ M 2 🔀 F	Age (In yrs. last		If Under 1 Yea Months Day		Min.	. Date of Birt (Month, Da	y, Year)	0	country)	(State or Foreign		
Director		219-16-9562 Usual Residence of Decedent	18 101 281	94	Yrs.			M	ar. 31	., 19	15   No	rth	Carolina		
land		10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. In	side City Limits		
Mary Frsh	to	Maryland Har	ford	Re <sup>1</sup>	L Air	_						1;	XTYes 2 □ No		
h the	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What C	ountry?			
th will		103 Stoneleigh F	Road			21014				U	SA				
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the "softcal Examinar must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏗 Divorced	12. Was Decede Armed Force 1 □Yes 2 If Yes, Give Year or Date	es? [ <b>X</b> No		Was Decedent of fYes, specify Cu I∐Yes 2ĂN			fy Yes or No- can, etc.)		4. Race - Am Black, Whi Specify:				
21215-0 I within 72 ho piene r than "natur	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16	a. Deced	dent's Usual Occ	upation e durina mos	st of working		16b. Kin	d of Business	s/Industry			
/ithin ne.	m d	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work don OO NOT use reti	red)	, , , , , , , , , , , , , , , , , , ,		-1					
2 2 -	Registration of the state of th								Eiret Middle		eaners				
be be	Be c	Gordon Cephus He	,					,	hina W		The state of the s				
	유	19a. Informant's Name/Relationship		1:	9b. Mailin	a Address (Stre					y or Town, State, Zip Code)				
and 2 seath a m 27 is	(4.7	David V. Edwards				Prospe							·/		
S 1 at S	Ī	20a. Method of Disposition		20b. Place		sition (Name of natory or other p		Dat			ation - City o		tate		
Pages nent of int: If ite		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate		iew Ceme	i	10-28	8-09	Fore	et Hil	11. N	Maryland		
Baltimore, Maperin: Pages 1 and 2 a Department of Health as Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Lic	ensee	Auto		Name and Add					DC 1111		ary rana		
<b>o</b> 89		* Kathleen	Illeur	CFSPCA		1317 Cok	esbury	Rd.,	Abing	idon,	MD 21	.009			
Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	sed the death. Dh line.	<i>l</i> − <i>f</i> e of):		ying, such as	s cardiac or I	espiratory ar	rrest,		Appr Inter Onse	oximate val Between et and Death		
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause (Disease or injury that mitiated events resulting in death) Last	c	as a consequenc											
44	edic		u												
<b>/ision of Vital Records, P.O. Box 6</b> Attending Physician: The law requires that the death certificate the activities of the this certificate has been signed by the attending toy the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2□Fetal dea nt at time of death		Ectopic pregna Other (specify)				2	3d. Date of de Month	elivery Day	Year		
ecords, P.O. law requires that the de as been signed by the 2 should be detached	ed by P	Part II. Other significant conditions	contributing to deat	h but not resulting	in the ur	nderfying cause g	iven in Part I	l. 			e contribute i		use of death?		
Reco	plet								24a. Was		24b. Were a	utopsy fir	ndings available ion of cause of		
The I	E									rmed? 2 No	death?	s 2 1			
Vital Fician: The certificate	Bec	25. Was case referred to medical	T.				26. Place	e of Death (	1 ☐ Yes Check only o		1 🗀 16	5 2 1341	¥0		
ohysic this ce		examiner? 1 Tes 2 No	Hospital: 1 ☐ Inp	atient 2 ER/0	Outpatien	t 3□DOA	ther: 4 🗖 No	ursing Home	5 ☐ Resid	dence 6	☐Other (Sp	ecify)			
On C	e l	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury 28b <i>Day, Year)</i>	. Time of Injury	28c. Ini	ury at ork?	28	d. Describe h	now injury	occurred				
Division of Vital Records, for the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be death.	Certification: To	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	M 1	⊒Yes 2□	1	Location (S City or Tow	Street and vn, State)	Number or F	Rural Rou	te Number,					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying I	Physician: To the beaminer: On the basi aminer: and manner	is of examination	ge, death and/or inv	occurred at the vestigation, in my	time, date a	nd place, an ath occurred	d due to the at the time,	cause(s) date and	and manner a	as stated. ue to the c	cause(s)		
To th To th comp	ž	29b. Signature and title of certifier				29c. Lice	nse number			29d. Date	signed (Mon	th, Day,	Year)		
		David 5 D				2.	3 2 29	)		ach	lun 2	6,20	10)		
5		30. Name and address of person wh		•	, , , ,	Print)		-							
~		DAVID DUNN - 61			D -	BEL AIR	MD 2	1014							
Stat Registra		31. Date filed (Month, Day, Year)		istrar's Signature	1.										

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Pl line a-c, Pll, 25, per ME g896 10/26/09 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 34299 1 - For State Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10/16/2009 **Physician** Joseph Fonte 9:20am M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 212–22–4015 **Funeral** Days Min Months Hours 1**½** M 2□ F 83 Yrs. 8/30/1926 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the medical Examinar must be retified at N/A X□Yes 2□No Baltimore City MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1124 E. Fort Avenue 21230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite may rightly or other traumatic event, it at Medical Exa. ili an ane. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: white 21215-0036 If Yes, Give Year or Dates: þ Specify: 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Produce Manager Ò 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Helen Luber Jospeh Fonte 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 East Fort Avenue, Baltimore MD 21230 Marlene H. Vogel / Daughter ore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 10/20/2009 Baltimore MD 9 4 Donation 5 Dother (Specify) 21. Sonaura Libraria Service Libraria Service Libraria P. Doda, Jr 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **End stage atherosclerotic disease** Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? aw 24a Was an autopsy or Attending Physician; The this certificate 2 **E**No 2 1 No 1 □ Yes 1 Tyes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) No. 71CAT Hospital: 1X Yes ZENO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Funeral 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D341476 10.18.2009 WD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST 4416 BALTIMORE RAYMOND W. WILSON MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 10 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name irst, Middle, Last) 2. Date of Death 3. Time of Death October 21 Physician/ 2009 7:26 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 6. Sex 1 X M 2 □ F 5. Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 04-04-1951 Months Hours Maryland Director 217-56-2677 58 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 K No MD Anne Arundel 0denton ō 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 21113 533 Bruce Ave. United States or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Specify. 3 Nidowed 4 Divorced White Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chesapeake Pools Pool Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Muriel Cooper William Franklin Forsyth, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shang beartment of Health an Important: If item 27 is Heidi E. Forsyth / Wife 533 Bruce Ave. Odenton, Maryland 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 10-24-2009 Odenton, Maryland uneral Service Sign Hora Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due towor as a cons Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a conseque resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No the g Unknown P.O. | þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed certificate 2 No 1 Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☑ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗀 No Μ Accident Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 3 29b. Signature and title of certifie 29c. License gumbe 29d, Date signed (Month, Day, Year) 2 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) 2/20

State

Registrar

filed (Month, Day,

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egistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:00 PM 4019 21 200 ivo Or to ber 9 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timor If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Number Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1 X M 2 □ F Director 212-42-1554 65 Jan 28, 1944 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Medical Examiner must be notified at 1 ☐ Yes 2▼ No Directo Maryland Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8071 Green Orchard Road Apt 12 United States 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify. 3 ☐ Widowed 4 ▼ Divorced White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 10th Dockman/Truck Driver Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lucille Louise Eardley <u> Joseph Woods Ford</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health as Important: If Item 27 Is any Injury or other trau Karen Elaine Klugel/daughter 8071 Green Orchard Road Apt 12 Glen Burnie, MD21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/24/2009 W Arundel Crematory Odenton, Maryland 21. Signa e of Funeral Service Licen Donaldson Funeral Home & Crematory, P.A. homas RI 1411 Annapolis Road Odenton, Maryland 211113 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician e to (or is a cons, quence of): CANCER disease or condition resulting in death) UNKNOWN /Medical Due to (or Examiner Eaquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 1 H 25. Was case referred to medical HAY boc Hospital 26. Place of Death (Check only one) Medical Certification: To Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inputient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending (Month, Day Year) Injury s after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760-6 Hospital

Baltimore, Maryland 21215-0036

State Registrar

filled in by

within 24 hours at

the

EEMA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South 300. 32. Registrar's Signature

and manner stated.

Street

1 🖫 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryl		oartment o <i>ertificate</i> (		Mental Hy	giene Reg. No		31,302			
			1. Decedent's Name (First, Middle, L	•				2. Date of De			3. Time of Death			
	Physicia /Medic		Gilbert Freder	ick Fauver				OCT	21	2009	9:56 A M			
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	Funeral		21.11	Sex 7. Age (In	yrs, last birthda	y) If Under 1 Y	ear   If Under 24 Hrs.		rth ,	N/A 9. Birth	nplace (State or Foreign			
	Director		212-46-4634	1XM 2□F 65		Months D	ays Hours Min.	Sep. 2	ay, Year) 29 <b>,</b> 1		ryland			
	nd *		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or	Location			<b>.</b>		10d. Inside City Limits			
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	the N	Director	MD N/A  10e. Street and Number			Baltim 10f. Zip Co			10g. Cit	izen of What Cou	untry?			
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	r dear	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 1	3. Was Decedent If Yes, specify	of Hispanic Orlgin? (S Cuban, Mexican, Puer	specify Yes or No to Rican, etc.)	0-	14. Race - Amer Black, White	rican Indian, , etc.			
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ano	I be fil intal F ed otl	Be	17. Father's Name (First, Middle, La. Raymond Joseph					•						
2 2	2 should be and Mental Is marked or raumatic ev	2	Raymond Joseph Fauver    Mary Elizabeth Schaffer   19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip											
Ø ≥ S	and 2 sealth a n 27 is		Cindy Ayers - [	aughters	82	33 Peach	Orchard R	d. Dune	ındalk, MD 21222					
gilbert altimore, Maryland	es 1 a of He fitem		20a. Method of Disposition  Burial 2 X Cremation 3	DRamoval from State	b. Place of Dis	position (Name of rematory or other Arunde	of r-place)	Date	20c. L	ocation - City or	Town, State			
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Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evartiner must be notified at once.	(	21 Tolland Function of L	Col Cartin	ap)					ral Home				
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	leath certific attending pl	/Mec	IF FEMALE:	23c. If yes, outcome of pro	egnancy					Dad Date of dol	luon.			
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Division of Vital Records,	after death after death Director:	Certification:	4 Homicide determine		At home, farm, pecify)	street, factory, of	fice	28f. Location City or To	(Street a. own, Stat	nd Number or Ru e)	ural Route Number,			
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by			Physician: To the best of my										
	he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medical Ex	aminer: On the basis of exa and manner stated.	mination and/o	r investigation, in	my opinion, death occ	urred at the time	e, date an	id place, and due	to the cause(s)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fb 897 11-4-09 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 2009 toher /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner al 8. Date of Birth Month, Day, Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int if item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No 10 Director 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Maryland 21215-0036 2 NO 1 ☐ Yes Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4or 5+) tomemas 18. Mother's Name (First, Middle, Maiden Surname) Mame (First, Middle, Last) 2 other traumatic ant's Name/Relatorship (Type. Prin Mailing Address (Street and Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory) other was transfer to the control of the Method of Disposition permit. Pages 1 Department of h Important: If it any Injury or c 2 Cremation 3 Removal from State Nestern 5 ☐ Other (Specify) f Funeral Service Licensee Signature Approximate Interval Between Onset and Death 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the failure. List only one cause on each line. Immediate C are (Final sease or condition resulting in death) SEPSIS Physician HOURS /Medical Due to (or as a consequence of) Examiner PNELMONIA HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of) the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be OBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No DIABETES certificate or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Certification: To 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTUBER 20, 2009 (CM) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE WANMOH . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Parte by Maryland 9 Gepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 2. Date of Death 10/19/2009 1. Decedent's Name (First, Middle, Last) **Physician** 0255 Ann Julie Grasham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐ XF Director Massachusetts JANuary 15,1936 001-26-0983 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan, that the redfilled at 1 ☐ Yes 🏖 ☐ No Director Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 USA Funeral 14306 Marsh Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Md. Dept. Social Services Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerome Rutherford Marie (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Upper Falls, Md. 21156 William Grasham Spouse 11525 Franklinville Rd. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-21-2009 Balto. Md. Bayview 22. Name and Address of Facility 21. Signature of Funeral Service Licensee. Schimunek FUneral Home 9705 Belair Rd. Nottingham, Md.2 1236 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

State Registrar 29a. Certifier

29b. Signature and title of pertiner

Benjamih

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Y. Lee, MD

M.D.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Revolution St., Havre de Grace,

D 0063981

29d. Date signed (Month, Day, Year)

19,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 4:00 PM **Physician** ARBARA ANN 22,2009 October /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner L'ARE NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🗷 F 81 EFTEMBER 13, 1928 MARYLAND 217-24-6528 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 MYes 2 □ No Director MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3939 Koland 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 📈 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 VNo ō Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) CONSULTANT MACY'S DEPARTMENT STORE VEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANN HULMES ഉ JOSEPH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (DAUGHTER) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 66 ORANGE RD., MONTELAIR, NJ 07042 JACQUELINE HOLMES CALHOUR 20b. Place of Disposition (Name of cemetery, crematory or other place)

5555 H. H. BROWN J. FUNERAL HOME + CREMATURY 10/87/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 505 PH H. BRDW H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses 3HON. FULTON AVE, BALTIMURE, MD 21817 Alliano 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cholimaco Physician Chrimmo disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Degenestra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for es a consecuence off Examiner burial-transi maemie and Due to (or as a consequence of): led by the attending physician detached for use as the burial 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 □Yes 2 ☑No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy performe 2 No 2 **∃**Nб 1 TYes 1 Tyes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this funeral c Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Patter death. After t 5 ☐ Pending investigation 1 THNatural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 24 hours 8 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MY

32. Registrar's Signature

A. HAPITONI

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821 N. EMTAN

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RAZIMORE MI)

Soute 3 and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Physician Arcum her /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County Examiner Jarylan General etimore If Under 1 Year | If Under 24 Hrs. Birth Day Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No MONE Funeral Director 10g. Citizen of What C 10f. Zip Code 10e. Street and Nambe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 2 Married 1 Never Married 1□Yes 2⊠No Specify. Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation f Business/Industry 15. Decedent's Education (Specify orly highest grade completed) Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other trainmate. Elementary (0-12) College (1-4or 5+) er's Name / First, Middle, Maiden Name 4First, Middle, Last Be Verman ပ (Mother rmant's Name Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Regte Number, City of DAHO iverman 20b. Place of Disposition (Name of cemetery, dematory or other i 20c. Location City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Donation Signature of Funeral Service Licensee Purt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Irm ediate Cause (Final sease or condition resulting in death) Physician Lung Cancin X 4240 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 3 Ectopic pregnancy for Month 5 ☐ Other (specify) 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 3 Probably 4 Unknown 2 No page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No After this certificate 2 🗆 No 1 □ Yes 1 Yes director, 25. Was case referred to medical example?1 ✓ Yes 2 ☐ No Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after deatl the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated when the cause of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of Medical er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and titl 29c. License number 0 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edelman Greene Registrar's Signature 31. Date filed (Moñth, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#11, 12, 15, 16a, b, 17, 20a-c&22
State of Maryland / Department of Health and Mental Hygiene O O O

	-	For State Of Maryland  - State Registrar	Certificate of De	eath	Reg. No.				
Physic /Medi	an	1. Decedent's Name (First, Middle, Last)	Hill	Month	Day 2009 10:00 AM				
Examil Funeral	er	4a. Facility Name (If not institution, give street and number)  Future Care Sandtown  5. Social Security Number  212-34-2752  1 ☑ M 2 ☐ F  72		nore					
Director ≥ _		Usual Residence of Decedent	y, Town or Location	вере 1	10d. Inside City Limits				
e Maryli Ba-f sho	Director		Baltimore 10f. Zip Code		Λ				
h with th		100. Street and Number 1000 N. Gilmore Street	2	21217	Reg. No.  2. Date of Death Month Day Year October 20, 2009  10:00 AM  4c. County of Death  4d. County of Death  4d. County of Death  4d. County of Death  4d. County of Death  4d. County of Death  4d. Rec - American Indian, Black, White, etc.  5c. Specify: black  6d. Specify: black  6				
15-0036 72 hours after death with the Maryland 72 hours after death with the Maryland 7 haturel', or frams 23a or 28a-f show coreal Examiner was be multified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 \( \begin{arried} \text{Muldowed} 4 \) Divorced \end{arried}  12. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 2 \( \begin{arried} \text{MV No UH} \)  15. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 2 \( \begin{arried} \text{MV No UH} \)  16. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 2 \( \beta \) No \( \text{UH} \)  17. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 2 \( \beta \) No \( \text{UH} \)  18. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 3 \( \beta \) 2 \( \beta \) No \( \text{UH} \)  18. Was Decedent Ever in U. Armed Forces?  1 \( \text{Yes} \) 3 \( \beta \) 4 \( \beta \) 3 \( \beta \) 3 \( \beta \) 4 \( \beta \) 3 \( \beta \) 3 \( \beta \) 4 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 5 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 7 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 6 \( \beta \) 7 \( \bet	<del>1K-</del>	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:					
0 2 E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupatio (Give kind of work done duri life. DO NOT use retired)	on ing most of working unk	ann				
d 2121 filed within Hygiene. wither than		12 unk 17. Father's Name (First, Middle, Last)	Bricklayer	3. Mother's Name (First, Middle					
yland build be filed Mental Hygarked otheratic event,	To Be	Bernard Hill							
Maryla 12 should Ith and Men 7 la marke		19a. Informant's Name/Relationship (Type, Print)							
re, f Hea f Hea othe		4 DRusial 2 Compation 3 DRomoval from State	Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State				
Baltimo permit. Page Department o Importent: If any injury or once.		1.42-11/11/11	Paltimore M	<del>(h 21201</del>					
Physician /Medical Examiner		23a. Part 1 Enter the disease, or complications that caused the deal shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a lonsed)	guence of):						
	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consect of the consect of	quence ot):	2 3000					
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	al death 3 ☐Ectopic pregnancy						
ds, Puires that signed by Id be deta	d by Pr	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given						
I Recor	Complete	typeaten	aut	opsy prior to completion of cause of death?					
n of Vita ng Physician after this certifican	To Be	27. Manner of Death 28a. Date of Injury (Month, Day Year)	□ ER/Outpatient 3 □ DOA Other  28b. Time of Injury Work?	at 28d. Describ	sidence 6 Other (Specify)				
Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attacomplately filled in by the fune	Certification:	2 DAGGGG	home, farm, street, factory, office	28f. Location					
Hospite 24 hours Funere	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr  2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death occurred at the time nation and/or investigation, in my opi	e, date and place, and due to the nion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)				
To the within ? To the comple	Mec	29b. Signature and title of certifier Ubecou	mb 29c. License		29d. Date signed (Month, Day, Year)				
7		30. Name and address of person who completed cause of death (Ite	em 23a) (Type, Print)	NO BAL	10/21/09 TOMD2/21/				
	tate	31. Date filed (Month, Day Year) 32. Registrant Sign	barle !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10-19 R 24 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore GILLINS thronox Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M Months Hours Min. June 7. Virginia **Director** 215-18-1401 89 Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland | Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 205 St Mark Way #421 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo White Specify. Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental F item 27 is marked of Wilson Hansborough Quesenberry Hanna Catherine Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State Zip Code). 2200 Rockey Point Road Baltimore, Maryland 21221 John H Messler Son item 27 or other 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any injury or o GreenMount Crematory Oct 29,2009 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Fa Mitchell-Wiedefeld Funeral Home Inc nature of Funeral S nnes 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or compl cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) orgestive Heavy Prysician/ /N.edical DRUS Due to (\*) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 Youths? Month Pregnant at time of death Day Year signed by the a 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director. After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 12 100 Other: 1 Yes DICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Watural 5 Pending 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) M 68286 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2120

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month; Day, Year)

27

amend # State Port MEHyland 6 Department of Health and Mental Hygiene 2009 34309 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0535 October 16 2009 RHONDA ELIZABETH HENDERSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A City Baltimore Dinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐XF 213-72-3220 47 Yrs. 9-23-1962 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County -how 10a. State r then "naturel", or items 23s or 28s-f ehov the Medical Examiner must be notified at 1 X Yes 2 No BALTIMORE Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 5420 CHANNING RD. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 2 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other then College (1-4or 5+) Elementary/Secondary (0-12) ATLANTA PUBLIC SCHOOLS TEACHER -12-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental BARBARA WYNN JUNE SPENCER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22202 19a. Informant's Name/Relationship (Type, Print) . 1400 S. JOYCE ST. APT 1240 ARLINGTON, VIRGINA nt of Health a :: If Item 27 is vor other tra NICHOLAS HENDERSON (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery
Woodlawn Cametery Date 20c. Location - City or Town, State 20a. Method of Disposition Peges in 1 ♣ Burial 2 🗹 Cremation 3 Removal from State permit. Peg Depurtment Important: II any injury o 10-31-2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fineral Service Licensee JONATAAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic shock day **Physician** /Medical Due to (or as a consequence of): Examiner End-stage renal disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellins Type 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ 140 1 ☐ Yes 2 0 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After the 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 - Natural 5 Pending 1 Yes 2 No ours efter death. neral Director; A filled in by the fu death. investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours e To the Funeral C Contriving Physicians To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signaturerand title of certifier October 26,2009 RES -000 completed cause of death (Item 23a) (Type, Print) 30. Name and ag spital of Baltimore MD Sinai 31. Date filed (Month. 32. Registrar's Signature State

Registrar

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			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No 2009 34310	7
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	Physic		Month Day Year	ı
No.	/Medi Examii		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
_,,,	E.A.		Franklin Square Hospital Center Rosedale Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months   Days   Hours   Min (Month Day Year)   Country)	n
	Director		Usual Residence of Decedent	
	yland row		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits	
	a-f sh	ict	MD Baltimore Middle River 1□Yes 2€□No	)
	h with the 23a or 28:	al Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify? Yes or No-Black, White, etc.)  14. Race - American Indian, Black, White, etc.  1 □ Yes 2 ☑ No Specify: Specify: White	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker  16b. Kind of Business/Industry  own home	
and		To Be Co	17. Father's Name (First, Middle, Last) William Edgar Hauf  18. Mother's Name (First, Middle, Maiden Surname) Anabelle Anna Noon	_
Mary	1 and 2 should Health and Mer em 27 is marke		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Henry Stanley Homberg/husband 9917 Bird River Road Balto. MD 21220	_
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra or		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   4 Donation 5 Other (Specify)   4 Donation 5 Other (Specify)   4 Donation 5 Other (Specify)   4 Donation 5 Other (Specify)   5 Other (Specify)	
Balti	permit. Departn Importa any inju		21. Signature of Fureral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Baltimore MI Connelly Funeral Home of Essex 21221	)
			23a. Part I. Enter the disease, Coy 1 is tions that caused they eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List 17 one cause on each line.  Approximate interval Between	_
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	
	Examiner	er	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
	xecuted and il-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Lucio (or as a consequence of):  c.  Due to (or as a consequence of):	
	ficate be executed physiclan and s the burial-transit	dical	. hyperkalemia	
.O. Box (	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 23d. Date of delivery Month Day Year	
о, С	s that gned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
ğ	w require been sign	ed	cia, atrial tibrilation, hypertension, 1 yes 2 No 3 Probably 4 Unknown	1
of Vital Records,	The law recate has be page 2 sho	Completed	history of pulmonary emboli  24a. Was an autopsy autopsy findings available prior to completion of cause of death?  1   Ves   2   No   1   Ves   2   No	)
/ita	sician: The certificate rector, page	Bec	25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
کر د	Physik rthis or ral dire		1 ☐ Yes 2 No	
n c	ding P h. After 1 funera	ü	27. Manner of Death 28a. Date of Injury 28b. Time of 1 ★ Natural 5 Pending 28b. Time of 1 Injury 28c. Injury at 28d. Describe how injury occurred Work?	
Division	or Attencter death irector: n by the i	Certification: To	2 Accident investigation   M   1 Yes 2 No   3 Suicide 6 Could not be determined   See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   See. Place of Injury - At home, farm, street, factory, office City or Town, State)   See. Place of Injury - At home, farm, street, factory, office City or Town, State)	
Ω	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		29a. Certifier  (Check only and manner as stated.)  Certifier (Check only and manner as stated.)  Certifier (Check only and manner as stated.)  Certifier (Check only and manner as stated.)  Certifier (Check only and manner as stated.)	'n
	the F thin 24 the F mpleti	Medical	and manner stated.	
	<b>5</b> ≥ <b>6</b> 8	-	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
	1	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	6V		To a the a start of the Company of the same Med 212	2-
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7
	Registr	ar	act 27 2009 Leven D. Jane	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:51p M Dc Month 22 Day 0 0 9 Year Bert L. Hammond Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 307 Essex Avenue Baltimore Essex Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 234-14-4236 Days Min Jan 2 Day, 15 M 2 □ F Months Hours 91 WVA Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Baltimore Essex 28a-f 1 Yes 2 X No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 307 Essex Avenue 21221 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Master Carpenter Owens Yacht Co. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Ceil Hammond Dessi Allen other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 James Hammond /son 3502 Cornwall Court Balto. MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot oak Lawn 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Avenue Balto. MD COnnelly Funeral Home of Essex 21221 COnnelly FUneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician disease or condition resulting in death) Hows Medical Due to (or as a consequence of Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury nding physician and use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XX Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cordifying Nurse Practioner: To the best of my knowledge, death on at the time, date and place, and due to the Signature and title of certifier 29d. Date signed (Month, Day, Year) Oct 23, 2009

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 23, 2009 Robert Edwin Hunter 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number Sex 1M M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours June 12, New York 1911 98 386-03-4117 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Marical Eva charactural be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue #350 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Tyes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ≥ 3 X Widowed 4 ☐ Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ernest Hunter Looloo Bell Moore မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce E. Hunter/Son 8400 Pittsfield Court, Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 27, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2009 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee, Million 23a. Part 1. Enter the disease, or complications that carised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the choline. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Dementia resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No 1 ☐Yes 2 ☐No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral ( 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo D0059423 October 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no Ndidi Feinberg, M.D. 11165/Stratfield Court, 1st Fl., Marriottsville, MD 21104 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1,30 per doc g896 10-27-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death George Jenkins -**Physician** 2009 rtober /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town or Location of Death Examiner DAHIMONE HOPKINS Hospita 9. Birthplace (State or Foleign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) (s. lastybirthday) **Funeral** Months Hours Aryland 5 Davs Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City Town or Logation 10d. Inside City Limits 10a. Sta 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at 1 Yes 2 □ No imo le Funeral Director 10f. Zip Code 10g. Citizen 10e. Street and Number Arkevau 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes 2\_Vo 14. Race - American I dian Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married Married 1 □Yes 2 ☑No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT | se retired) 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) ame (First, Middle, Maiden Surname) 17. Father's Name (First, Middle Last) Be h and Mental F is marked of ٩ Number, City or Town State, Zip Code) 19b. Mailing Address (Street and Number or Rural Rough Informant's Name/Relationship WNS FAISS of Health a Department of Health Important: If item 27 any Injury or other tr. once. 20a. Method of Disposition 1 🗆 Burial Cremation 3 Removal from State ☐Other (Specify) 4 ☐ Donation 21. Signature of Fu eral Service License Approximate Interval Between Onset and Death 23a. Pa 1. En er the dise ase, or complications that caused the death. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate ( ause (Fin disease or ondition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o s a consequence of) Physician/Medical Examiner he law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificale has been signed by the funeral director, pege 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 □ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rylicse600N. Wolfe Street Balto. Md. 21287 Steven 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** George Thomas Jenkins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Towson Balto. Manor Care Ruxton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 14, 1933 Maryland 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ★M 2 ☐ F Months Days Hours Min. Director 219-28-0536 76 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wicking Examinant runst be notified at 1 ☐ Yes 2√2 No Director Middle River Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 6934 Gunder Avenue Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give 1954- 1956 The 2 No 'natural", or White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) 12 State of Maryland Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Leimkuler Thomas B. Jenkins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Jenkins 6934 Gunder Avenue Middle River, Md. Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-26-2009 Holly Hills Mem. Middle River, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** avionson /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if y leading to minimal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of sician and burial-transit Due to (or as a consequence of): physician the burial Physician/Medical attending p for use as 1 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I 1 Tyes Be Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, death. after death Director:

altimore, Maryland 21215-0036

filled in by To the Hospital of within 24 hours a To the Funeral D completely

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

of person who completed cause of death (ten 23a) (Type, Print) 30. Name and addr 0

31. Date filed (Month, Day, Year) 7

29a. Certifier

(Check only one)

32./Registrar's Signature

State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 [] [] 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 23, 200 gar 4:45 P M KENNETH ASHTON JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Edgewood 1248 Valley Leaf Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Hours Months 1 XM 2 ☐ F Days Washington, DC Director 3, 1938 578-52**-**8721 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminant to retified at any Injury or other traumatic event, the Medical Exeminant has the retified at any once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Directo Maryland | Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21040 1248 Valley Leaf Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Zives 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify. þ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpet Retailer Carpet Installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Mueller Hedgman William Ralph Johnson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2704 Long Meadow Drive, Abingdon, Maryland 21009 <u>Georgia M. Verry / Daughter</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Remo State Aberdeen, Maryland Paul's Lutheran Cem. 11-2-09 4 □ Donation 5 □ Oner (Specify) 21. Signa e of Fune 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Purt . Enter the disease, it complies that the caused the shock, or hear failure. List only one cause on each line. Do not enter the make of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** dey disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and ned for use as the burial-trar the burial-trar that initiated events P.O. Box 68760, 2 resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) n signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part // Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed 1 ☐Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 120 o completed cause of death (Item 23a) ame and a VO TK 32. Registrar's Signature . Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** JOHNSON 23:58 JESSIE **JAMES** October 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD CO BELATE 6. Sex **XX**M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 80 Director 219-22-6759 25 1929 MARYLAND Usual Residence of Decedent 10a State 10c. City, Town or Location 10d, Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No Director HARFORD CO MARYLAND **EDGEWOOD** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2016 BROWN ST. Funeral 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 🗓 No <u>ک</u> Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HARFORD CO Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. CUSTODIAN SCHOOL SYSTEM 8th grade is marked other Maryfand 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ' ပ္ unknown MARY DIXON LANGFORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.9
Department of Health an Important: If Item 27 is any injury or other trauonce. Kenneth L. Johnson/ Son 1541 Arena Rd., Street, Md., 21154 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL GRDNS 10-28-09 ABERDEEN, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 21. Signature of Fugeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical as use 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has autopsy performed? Yes 2 No certificate 1 □Yes Vital Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anne 31. Date filed (Month, Day, Year) 82. Registrar's Signature State OCT 27 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0745AM 10 18 9 0 n15 /Medical 4c. County of Death 4b. City. Town, or Lecation of Death lame (If not institution, give st Examiner SALL'MOKE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex My miland 1 □ M 2 🗱 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County DAH. more 1 Yes 2 □ No Director 10g. Citizen of What Country 10f. Zip Code 10e Street and Number Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) h**er**'s Name *(First, Middle, Maiden Surname)* 17. Father's Name (First, Middle Last) Be e/1 lice 2 19a, Informati's Name/Relationship (Type. ce 20b. Place of Disposition (Name of City or Town, State 20c Location 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Sign dure of Funeral Service Licensee 23a. P. 1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or hear failure. List only one cause on each line.

Impudiate Cause final Island or condition such as a cardiac or respiratory arrest, as a constant of the condition of the condition of the condition of the cardiac or respiratory arrest, as a condition of the cardiac or respiratory arrest, and the cause of the cardiac or respiratory arrest, as a cardiac or respiratory arrest, as a cardiac or respiratory arrest, and the cardiac or respiratory arrest, as a cardiac or respiratory arrest, and the cardiac or respiratory arrest, as a cardiac or respiratory arrest, as Approximate Interval Between Onset and Death Smallcell nouroendocrine lung cancer Due to (or as a consequence of): metastance Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hupertension Due to (or as a consequence of): theroscierotec Cardiovasulas disense Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ep afeter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? hizophrenic 24a. Was an autopsy performed? Be Certification: To

/Medical Examiner the death certificate be executed burial-tran physician the as

**Physician** 

Important: if any injury o

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Records,

Division or Vital or Attending Physician:

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25.	. Was case refer	red to medical	V-			26. Place o rea	1   Yes 2  No   1   Yes 2  No   1   Yes 2  No   1   Yes 2  No   1   Yes 2  No   1   Yes 2  No   No   No   Yes 2  No   No   No   No   No   No   No   N	)		
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one)	and manner stated.	
29b. Signature and title of certifier	1	
· u.	/	NI

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Eufaw 5t. Suite 3

State Registrar

Medical

31. Date filed (Month, Day, Year)

Eutaw

32 Registrar's Signature

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

Thomas Edward K			e of Maryla				and N	Mental H	ygiene	J	•	0.0		010	
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Physician Medical Examine		Decedent's Name (First, Middle,		s Edward	d Kurek				2. Date of I Month Octobe	Da	2009		0902 h		
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Funeral	1	5. Social Security Number 6	. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Months	$\overline{}$	If Under 24Hrs Hours Min	_			Cour	ntry)	e or roleigh	
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21215-0036 uld be filed within 7 Mental Hygiene. event, the Medica	ပေျ	17. Father's Name (First, Middle, L		_			18.				den Surname)				
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re, MD 2: 1 and 2 should FHealth and M fitem 27 is m	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Mrs. Linda Paros (Sister)  525 Hanna Road Bel Air, Maryland 21														
and 2 sho ealth and 2 traumat	+	Mrs. Linda Pal 20a. Method of Disposition	os (SISI	20b. F	Place of Dispos	ition (Name			Date	12	Oc. Location -	City or	Fown, Stat	e	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	4 Denation 3 Other Special Service L			/ 22. N	lame and Ac	idress of	Facility						and	
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Box e death c the atten	ysici	1 Yes 2 No 9 Unki		nown	eath 5 O	ther (Specif	y)			-					
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Division of Vital rat or Attending Physician: rs after death.  The Director: After this certiled in by the funeral director.	-1	27. Manner of Death	28a. Dat	e of Injury th, Day,Year) D:	28b. Time of	· ·		at Work?	28d. Des Subject		w injury occur self	red			
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VIS or At ufter d Direct in by	ij	3 V Suicide 6 Could	not be 28e. Pla	ace of Injury - At h	nome, farm, stre	et, factory, o	office bu	ilding, etc.	28f. Loca or To	ition (Sta	reet and Numb ite) Road, Dunda	er or Ru	ıral Route	Number, City	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be thours after death. Funeral Director: After this certificate has been signed by the attending physitely filled in by the funeral director, page 2 should be detached for use as the bure.	Certification:	4 Homicide		Woods					-						
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a Certifier 1 Certifying Phone) 2 Medical Exam	ysician: To the be	s of examination a	ige, death occu and/or investiga	rred at the ti ation, in my o	ime, date opinion,	e and place, ai death occurred	nd due to the d at the time	e cause , date ai	(s) and manne nd place, and	er as stat due to th	ed. ne cause(s	)	
To with	Me	296. Signature and title of certifie	and manner	stated.			License				29d. Date sign				
		( ) Carlin	le Mil)				O.C.M	I.E.			October 2	3, 200	9		
2		30. Name and address of person	who completed ca	use of death (Iter											
2			ssistant Medic			n Street,	Baltim	ore, MD 21	1201						
Sta Regist		31. Date filed (Month, Day, Year)	2009	Registrar's Signat	B. Sa	when I			. <u>-</u>						
		001 40	1		4 1/										

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 2:15 October 0 26, KEATING JAMES GERARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 313 Woodbourne Avenue If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 10, 1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2**X** F Maryland 95 Director 216-10-8983 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, the Modical Exercites must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 Yes 2 No Funeral Director N/A Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 U.S.A. 313 Woodbourne Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent Ever III O.S. Armed Forces? 1XYes 2 □ No IfYes, Give Year or Dates: WWII 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Liquor Store Proprietor 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellie Butler ၀ Richard Keating 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 301 West 2nd. Street Frederick, Maryland (son) James E. Keating 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory Oct 27,2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee Joseph Leccuse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) ed by the a detached f 9 I Inknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed/ 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No or Attending Physician: After this certification, partitions 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit 1 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of PIERRE & OR STIGI CM MOCENS TOWSON MI 141 Jes 120 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 4:00 Robert A M Kantorski Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8410 Tachbrook Road White Marsh If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye October 19 1 🖾 M 2 🗆 F Months Mary land 1940 214-38-0168 Director 69 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 8410 Tachbrook Road 21236 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 X Married ☐ Yes Maryland 21215-0036 1 Tes 2 No Specify. If Yes, Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hyglene. marked other than 12 years College (1-4 or 5+) 4 years Pharmacy Owner Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Joseph Kantorski Stella Jedrzejczak permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8410 Tachbrook Road, Perry Hall, Maryland Barbara Kantorski wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 28 1 X Burial 2 Cremation 3 Removal from State Cardens of Faith Cemetery Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Funeral Service Licensee Comment of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications at c shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exam Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregna5 Other (specify) Ectopic pregnancy ō in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 🗌 Yes 2 🗆 No ☐ Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

only on

30. Name and a

chard 31. Date filed (Month, Day, Year)

ress of person who comp

29b. Sig

(4)

(Item 23a) (Type, Print)

Signature

ng Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

7505 Osler

. License numbe

29d. Date signed (Month, Day, Year)

10-26-09

Drive Suite 302

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line b per MD 8896 10/27/09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar 34321 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Henrietta J. Leonowicz October 2009  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Pay, Days 1 M 2 🔯 Hours Min. Pennsylvania 203-18-8978 82 **Director** Ĩ926 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Anne Arundel Maryland Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 818 Buena Vista Avenue 21012 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic assets. Elementary/Seconday (0-12) College (1-4 or 5+) Operator Paper Box Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Leonowicz Victoria Banaszak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristine Lowe 818 Buena Vista Ave., Arnold, MD 21012 (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery 4 Donation 5 Other (Specify) 10/24/09 Bensalem, PA 22. Name and Address of Facility Tomaszewski Funeral Home 2728-30 East Alleghany Ave. 21. Signature of Funeral Service Licensee <u>Philadelphia</u>, <u>PA</u> . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shook, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Urinary tract infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mont Day Pregnant at time of death Month Year ate has been signed by the a page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? ₁ ☐ Yes 1 🗌 Yes 2 🗌 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature D00058797 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d Annedrundel Medial Center Annapais MD Z140) MO HOWARD OUN 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:55 PM OCTOBEY 22 William E 2000 Lawson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Balhmore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** XXM 2□F Days Hours Maryland Director 220-56-1080 57 May 11, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Mccical Examiner is ust be notified at Director 1 ☐ Yes 2√CXNo MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2044 Horseshoe Circle 20794 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes XXNo Specify. White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Superintendent Associated Builders 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Everett Lawson Mary Rosalee Wiant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Lawson/Wife 2044 Horseshoe Circle, 20794 Jessup, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/28/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, M01103 313 Talbott Avenue, 20707 Laurel, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one can see on each line. Immediate Cause (Final **Physician** a. Infective Endocarditis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, see ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **№**No 1 ☐Yes 2 ☑No 1 □ Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ∐ Yes 2 📉 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled in Hospital 29a Certifier Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1518798310 October 22, 2009 MD Ker 30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print) 22 Baltimore, MD 21201 Street Greene Snarker 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem 5 per fh 9896 10-27-09 vt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death MCDOWELL 11 **Physician** 10 0 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Deat 1417 SECOURS HODDITAI 7. Age (In yrs. 9. Birthplace (State or Foreign Country) Arof; n If Under 1 Year | If Under 24 Hrs. birthday) 8. Date of Birth **Funeral** 1**X**.M 2□ F Min Months Days Hours Director (Arolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shorevent, the Medical Examinar must be notified at 1 Yes 2 □ No Director none 10e. Street and Number 10f. Zip Code 10g. Citizen of Wh Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - Ame Black, White 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 📉 0 Š Specify 3 ☐ Widowed 4 Pivorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use refred) ary/Secondary (0-13) College (1-4or 5+) Ontractor item 27 Is marked other other other traumatic event. First, Middle 17. Fathe 18. Mothey's Name (First, Middle, Maiden Surname) 020011 ဥ CI Number or Rural Route Number, City or Town. State, Zip Code Health a Department of Heal Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) f Funeral Service Licensee gnature 00 Pirt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) **Physician** /Medical e to (or as a consequence of) ≟xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executer burial-transi and Due to (or as a consequence of the attending physician P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year signed by the a 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 □ Yes 1 ☐ Yes 2) director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Date of Injury (Month, Day, Year) 27. Manner of Death To the Funeral Director: After completely filled in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending Natural 5 Pending Injury death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MVEWBA am

Registrar DHMH 17 Rev 1/2001

State

Date filed (Month, Day, Year)

Common Wes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 16b per fh g896 10-27-09
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 2009 1 - State Registrar 34324 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Swendolyn Day Year 4:31 AM OCTOBER 19,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AYENUE EVERGREEN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months 216-36-2921 70 3,1939 Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 23a or 28a-f show 10d. Inside City Limits Evanither must be notified at Director 1 XYes 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 3624 EVERGREEN U.S.A Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White oc. or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify 3 ¥Widowed 4 ☐ Divorced 7 is marked other than "natural", traumatic event, the Medical Eva Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Domestic eondary (0-12) College (1-4or 5+) tomemaker 17. Eather's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) Be 060211 ၀ 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Josh, State/Zip Code)
3624 Evergreen Ack DA Fimore Jonship (Type Print) imore Health a 501 permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tra 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Place of Disposition Name of 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. P t1 Enter the disease ho k, or heart failure. ase, or complications that caused the death.
re. List only one cause are each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death I minedir te Cause (F' - I sear e or condition estriting in death) **Physician** /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if an accuse Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consecuence of attending physician and for use as the burial-transi The law requires that the death certificate be execute Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 □Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) 1 Yes 2 No While care 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 ☐ Accident 5 Pending investigation within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 🗆 No the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death October 22 Bay 2009 Barbara Diehl Magnanelli 12:22 A<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6213 Madawaska Road Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🕅 F 579-18-5443 89 1920 Maryland May 16, Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔽 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6213 Madawaska Road 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Institute Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant of Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert S. Diehl Rosa May Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter T. Magnanelli/Husband 6213 Madawaska Road, Bethesda, Maryland 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. shart in M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Paralysis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Stroke Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 □ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be ည

death with the Maryland

/Medical

and burial-trar signed by the attending physician I be detached for use as the burla Physician/Medical þ cate has been signal page 2 should b Completed certificate Be Certification: To funeral After Hospital or Attending

 $\# \triangle c + \bot + \Box$  Division of Vital Records, P.O. Box 68:

IF FEMALE: 23b. Was decedent pregnant

Dysphagia

Deep Vein Thrombosis

Urinary Tract Infection

27. Manner of Death

1 XNatural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

28d. Describe how injury occurred

M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

(Check only one

> 29c. License number D34726

29d. Date signed (Month, Day, Year) October 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jasmine C. Gatti, M.D. 5219 Ridgefield Road, Bethesda, Maryland 20816 31. Date filed (Month, Day, Year)

State Registrar



DHMH 17 Rev 1/2001

death.

24 hours after deatle Funeral Director:

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filled in by

Medical

			1 _ State	partment of Health and M		
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg	, No. 2009 34326
П	Physic		NORMA SOPHIA MYERS		10/21/2	Day Year
N. S.	/Medi Examiı		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10/21/2	4c. County of Death
and .			185 Kenwood Road	Pasadena		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Y) 10/29/1	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		10/29/1	919   Maryland
	rylanc how		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Ba-f s	octo	MD Anne Arundel	Pasadena		1 ☐ Yes 2 ☐ No
	a or 2	Dir	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show hy Mudical Evaminar coust by invillind at	<b>Funeral Director</b>	185 Kenwood Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21122	osifu Vo o or No	U.S.A.
9	or iten	F	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
15-(	"natu	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gin	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired)	ng 16	b. Kind of Business/Industry
12	within lene. than	dwc	College (1-40r 5+)	omemaker		Own Home
DQ 5	a filed value other vent, t	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	
/lar	uld be Menta Irked Itic ev	10 B	James Francis Herold	Ju1	ia Loui	se Romor
Maryland	2 sho and is ma	i.	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rura		
e, <b>r</b>	l and tealth em 27 ther tr		Renea L. Skovron / Daughter   780	<u> 7 Hidden Creek Wa</u>		
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, 100ce.		122 Barriar 2 2 Cremation 6 2 Heritoval Horit State	ematory or other place)	ate 200	c. Location - City or Town, State
Ħ	artme ortan Injury		4 □ Donation 5 □ Other (Specify) Oaklawn  21. Signature of Emeral Service Licensee	Cemetery 10/26	5/09   I	Baltimore, MD
Ba	Depar Impo any Ir			.69 Riviera Driv	o Pasa	Funeral Home, PA dena. MD 21122
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			
4	Physician	i i	Immediate Cause (Final disease or condition			Onset and Death
26	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	Zammer	<u>-</u>	Sequentially list conditions, if any, leading to immediate  b.			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
o,	an an rial-tr	Еха	resulting in death) Last  Due to (or as a consequence of):			
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	ding p	/Mec	IF FEMALE:			
Вох	death certifi e attending p d for use as	Physician/Me	4 Dramont at time of death	Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	0 0 0	ysi	1   Yes 2 No 4   Fregnant at time of death 5 9   Unknown	Other (specify)		
s, P.	The law requires that the ate has been signed by thosage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ğ	w require been sig should b	edb			1 ☐ Yes	2 No 3 Probably 4 Unknown
Record	e faw re has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>~</u>	: The cate ha	Co			performed	d? death?
<u> </u>	Physician: The riths certificate I director, page	Be	25. Was case referred to medical examiner?    To Vac 2	26. Place of Death		
ō	Physer this eral di	5	1 ☐ Yes 2 ☐ No Pospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of Death		ne 5 Residence 8d. Describe how i	e 6 Other (Specify)
<u>o</u>	nding Fath.	atio	1 X Natural 5 ☐ Pending (Month, Ďaý, Year) Injury 2 ☐ Accident investigation	of 28c. Injury at 2. Work?  M 1 □ Yes 2 □ No	od. Describe now i	njury occurred
Division of Vital	r Attencer death	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	8f. Location (Stree City or Town, S	t and Number or Rural Route Number,
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	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of contries	29c. License number	29d.	Date signed (Month, Day, Year)
			· Companules Cont	R118354		0/22/09
	ł		30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number  R118354  Print)  int Ct Pasadera		
	Stat		Any Schuler CRNP 1900 Oak Po	int Ct Pasadena	MD 21	1182
	Stat Registra	~	OCT 27 2009 Server S. Jan			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 34327 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mean Month 1:55 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Annove Baltoner Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 F Min 02/01/1965 Months 217-90-6535 Director Yrs. Usual Residence of Decedent 10b. County 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Owings Mills 1 ☐ Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral West Road 21204 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/A Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles L. Meahl Elizabeth C. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Morsberger/Mother 3009 Merrymans Mill Road, Phoenix, MD 21131 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 10/26/2009 Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ardent Cremation Serrvices any Lama C. Hardesty M01197 7522 Connelley Drive, ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AS Physician/ piratun neumonia disease or condition usee Medical resulting in death) Due to (Ir as a consequence of): Examiner uzeus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): nding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records. Completed No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No Yes 1 Tyes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be s after death Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year) 68286 200 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **(**2) le

State Registrar 31. Date filed (Month

09-08201 James Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mes Martin	1	State of Maryland / De	epartment o C <i>ertificate</i> o		nd Mental Hy		20	09 3432
Physicia	F	Registrar  1. Decedent's Name (First, Middle,Last)	<del>Jei tilleate t</del>	or Death		2. Date of Death	. 140.	3. Time of Death
edical Examin	er	James	Marti			Month October 22		1108 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Deatl	
Formand	4	Johns Hopkins Bayview Medical Center  5. Social Security Number 6. Sex 7. Age (In.)	yrs. last birthday)		ear If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or Foreign
Funeral Director		210 10 7010			ays Hours Min.			ountry) aryland
	}	219-10-7019 1X M 2 F 8  Usual Residence of Decedent	4			J Sept.	291725 11	
v any		10a. State 10b. County 10c.	City, Town or Loc	cation				10d. Inside City Limits  1 Yes 2 XNo
Maryland 28a-f show d at once.	اة	Maryland Baltimore		Du 10f. Zip Code	ındalk	110	g. Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		Tor. Zip Code	21222	i	United St	
rith the s 23a c		7550 Rabon Avenue  11. Marital Status 12. Was Decedent Ever	in U.S. 13.1	Was Decedent of I	Hispanic Origin? ( Sp		14. Race - Ame	rican Indian, Black,
leath v r item	Funeral	1 Never Married 2 XMarried Armed Forces?	No I	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	White, etc.	
after c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2X		and days	Specify: 16b. Kind of Business	White
936 thin 72 hours a ne. r than "natural ledical Examin	E E	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+)	ed) 16a. Deced during	dent's Usual Occup g most of working l	pation (Give kind of vi ife. DO NOT use reti	red)	100. Killy of business	/ilidusti y
36 thin 72 te. than *	ompleted	12 Years	Auto	omobile N	lechanic		Tate En	geering
21215-0036 uld be filed within 7 Mental Hygiene marked other than evernt, the Medica	틼	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle, M		
2121 ald be fil Mental F marked	B	Ira Ambrose Martin	140h Ma	iling Addrone (Ct		Pope	ber, City or Town, Sta	te Zin Code)
O용점·호텔	유	19a. Informant's Name/Relationship (Type, Print)  Margaret M. Martin (Wife)	1	550 Rabor			Maryland	4.
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	1	20a. Method of Disposition	20b. Place of Dis	position (Name of rother place)		Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If iteliminary or other tr		1 Burial 2 Cremation 3 Removal from State			esus Cem.	10/26/2	009 Dunda	lk, Maryland
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E P P W	- (1	234. Part I. Enter the disease, or complications that caused the		7922 Wi	se Ave. D	undalk.	Maryland	21222 Approximate Interval
Physician	- 1	failure. List only one cause on each line.				or respiratory arre	sat, shook, or hour	Between Onset and Death
caminer		Immediate Caus Final disease or condition resulting in death)  a. Hypertensive Ather Due to (or as a conseque		irdiovascular i	Disease			
		Sequentially list conditions, b						
	miner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause	nce of):					
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60, ate be ex hysician e burial	Nedi	IF FEMALE: 23c. If yes, outcome o	f pregnancy				23d. Date of deliv	егу
Sox 6876 leath certificate e attending phy for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?	2	Fetal death	3 Ectopic pregn	nancy	Month	Day Year
Box e death o the atten	ysic	1 Yes 2 No 9 Unknown 9 Unknown	e or death 5	Other (Specify)				
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ords, aw requir as been s 2 should	plet					auto	osy prior t ermed? death	o completion of cause of ?
tal Recor	Completed				Described to the second	1 Yes	2 No 1 🗸	Yes 2 No
ital sician: s certi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient	2 🗸 ER/Outpat		Other: Nurs	ing Home 5	Residence 6 Ot	her:
n of Vital Rec ing Physician: The I After this certificate I funeral director, page	5.7	1 V Yes 2 No  27. Manner of Death  28a. Date of Injury (Month, Day, Year)			Injury at Work?	28d. Describe	how injury occurred	
On tendin sath.	ation	1 Natural 5 Pending 2 Accident Investigation		1[	Yes 2 No			
Division pital or Attene ours after death teral Director:	Certification:	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm,	street, factory, off	ice building, etc.	28f. Location ( or Town,		Rural Route Number, City
Divisior Bospital or Attend 24 hours after death Funeral Director:		4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my kr		accurred at the tim	e date and place ar	nd due to the cau	se(s) and manner as s	tated.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner:On the basis of examina	ation and/or inves	stigation, in my opi	inion, death occurred	at the time, date	and place, and due to	the cause(s)
To To con	Me	and manner stated.  29b. Signature and title of certifier	18	29c. Li	cense number		29d. Date signed (	-
		Call to		0	o.C.M.E.		October 23, 20	
isti		30. Name and address of person who completed cause of deat Zabiullah Ali, M.D. Assistant Medical Exar		Penn Street I	Baltimore, MD 2	1201		
	200	CA Designated	Cignoture	76.5				
St Regist	ate	0000	A MA	Media				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav 3:03 PM **Physician** Charles D. Mellott +Ober 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) Hours 85 196-14-8368 1 ☑ M 2 □ F Yrs. May 30, 1924 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2805 Huntingdon Avenue 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XIYes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Baltimore Glass College (1-4or 5+) Glassman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Mellott Stella Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2937 Huntingdon Avenue Baltimore Maryland 21211 William Bayer/stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/27/09 Towson Maryland 4 □ Donation 5 □ Other (Specify) 123 Name and Address of Facility 5385 Harriord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) g  $\square$  Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□**1√0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28d. Describe how injury occurred

burial-transit Box 68760,00 attending physician the as for Division of Vital Records, P.O. funeral director,

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland is and Merital Hygiene.

Is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 to Department of Health at Important: If item 27 Is any injury or other trau

**Physician** /Medical

Baltimore, Maryland 21215-0036

? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanting must be swifted at

Examiner Examiner Physician/Medical ð Completed Be Certification: To Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 1 🛮 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier f 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DC064788

29d. Date signed (Month, Day, Year) 0

30. Name and address of per-on who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SHARM W MT. ROYAL AVE, BALTIMORE IJA 1600 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar

			1 - State Registrar	e of Maryland		rtment of H		Re	g. No 2009	
ı	Physici	an	1. Decedent's Name (First, Middle, Last) HOPE KIMBROUGH McC	CROSKEY				2. Date of Death October		3. Time of Death 11:10P M
	/Medio		4a. Facility Name (If not institution, give street ar				Location of Death		4c. County of Death	n
	Funeral		Keswick  5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	Baltimor If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	None 9. Birth	nplace (State or Foreign
Ŀ	Director		533-12-9568 ¹□м X9	(F 91	Yrs.	Months Days	Hours Min.	8. Date of Birth	918 Wast	Tington
	yland		Usual Residence of Decedent  10a. State 10b. County	1	, Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-f s	recto	Maryland Baltimore	Bal	timore	10f. Zip Code		10	og. Citizen of What Co	1 ☐ Yes 2 <b>X</b> No untry?
	23a or	al Di	7101 Travertine Drive	#106		21207			USA	
036	be filed within 72 hours after death with the Maryland that Hyglene.  Id other than "natural", or items 23a or 28a-f show event, the Medicol Exartinat harman be notified at	by Funeral Directo	1 ☐ Never Married 2 ☐ Married 1 ☐ If Ye	Decedent Ever in U.sed Forces? Yes 2 No s, Give r or Dates:	1	Was Decedent of H f Yes, specify Cuba I □Yes 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0036	"natura	leted	15. Decedent's Education (Specify only highest grade compl	eted)	16a. Deced	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor	rking	6b. Kind of Business/	ndustry
717	d within 72 giene. er than "na i the Medic	Completed	Elementary/Secondary (0-12) College 5-	ege (1-4or 5+) -		omemaker			Own Home	<u> </u>
yland	should be filed of the should be the hygin marked other imatic event, It	To Be (	17. Father's Name (First, Middle, Last) Samuel Arthur Kimbroug	gh				Mother's Name (First, Middle, Maiden Surname) Gladys McCroskey		
Mar	S S S		19a. Informant's Name/Relationship (Type. Prin Jill McCroskey Coupe	n Dtr					. City or Town, State, 2 timore, Mai	Cip Code)  Tyland 21207
altimore,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tra		20a. Method of Disposition 1 ☐ Burial 2 K remation 3 ☐ Removal	20c. Location - City or						
	permit. Pages Department of Important: If it any Injury or one.		4☐ Donation 5 ☐ Other (Specify)  21 Aignature of Funer → Fee Licensee	/ Gree		t Cremato R. Name and Addre			Baltimore, efeld Fune	ral Home Inc
ñ	Dep Imp any	10 g	Newnes Digaren /	Maris	1				ore, Maryla	and 21212 Approximate
	Physician	W	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	that caused the death on each line. Aspiration F			ng, such as cardia	c or respiratory arr	est,	Interval Between Opset and Death 4 ClayS
	/Medical Examiner		regulating in double)	ue to (or as a consequ Alzheimer¹s		 а				5 years
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequ						
δ. ⊃	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequ	uence of):					
8/60,	icate be physicia the bu	dical	d							
O. Box t	attending for use a	Physician/Me	in the past 12 months?	es, outcome of pregna   Live birth 2	Ideath 3	Ectopic pregnand Other (specify)	çy		23d. Date of de Month	livery Day Year
J.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributin	g to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	1	bacco use contribute to	o the cause of death?
I Hecords,	The lar ate has page 2	Completed						24a. Was a autops perfort 1 □Yes	y prior to ned? death?	utopsy findings available completion of cause of
Vital		Be	25. Was case referred to medical examiner? 1 Yes XX No Hospital	1 ☐ Inpatient 2 ☐	FB/Outnaties	ot 3 DOA Oth		ath (Check only on	e) ence 6 □Other (Spe	ncify)
n of	Ing Ine	on: To		Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Inju	ry at k?		ow injury occurred	, and the second
Division of	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director; After completely filled in by the funera	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At he building, etc. (Specif	ome, farm, str		Yes 2□No	28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	Hospital		29a. Certifier (Check only 2 Medical Examiner: Or	the basis of examina	wledge, deat	th occurred at the ti	ime, date and plac opinion, death occ	ce, and due to the courred at the time, of	cause(s) and manner a late and place, and du	is stated. e to the cause(s)
	To the within 2 To the comple	Medical	one) and 29b. Signature and title of certifier	d manner stated.		29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
			Windle Cy-	mp			63576		October	26, 2009
	4		30. Name and address of person who complete Danelle Cayea MD 5	d cause of death (Iten 505 Hopkins I	Bayview	Circle Bal	timore, Ma	ryland 2122	4	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture .	baile				

7			1- For State of Maryland / Department of Health and Me Certificate of Death	Reg. N	711114	34331
	Physicia	an	1. Decedent a reality (1 mail mineral)	2. Date of Death Month D	Day Year	3. Time of Death
0	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
				CITY Date of Righ	N/A	place (State or Foreign
1	Funeral Director		220-20-3433 1♥ M 2□ F 82 Yrs. Months Days Hours Min.	3. Date of Birth (Month, Day, Yea 10-1-192		YLAND
)	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ン フ マ	Ba-f sl	ector	MD. N/A BALTIMORE			1 XYes 2 No
7	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f show he Madicel Examinat must be motified at	Funeral Director	10e. Street and Number 4224 FORDS LANE 10f. Zip Code 21215	10g. C	Citizen of What Cou USA	untry?
2	er deat	uner	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married  14. Yes 2 □ No  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White	
2-0036	ours aft	þ	If Yes, Give 1 ☐ Yes 2√2 No Specify: Year or Dates:		Specify: BL	ACK
15-0	in 72 hours a "natural", c	Completed	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work one during most of working life. DO NOT use retired)	16b.	. Kind of Business/Ir	ndustry
2121	filed within Hygiene.	Com	Elementary/Secondary (0·12) College (1·4or 5+) LABORER			ER & BRASS
Maryland	2 a a 5	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (i		en Sumame)	
ary	d 2 should th and Men th marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural II		y or Town, State, Zi	ip Code)
	1 and 1 dealth sm 27 ther tr		JOSEPHINE MULDROW (WIFE) 4224 FORDS LANE BALTIMOI  20a. Method of Disposition (Name of Date of Date of Disposition (Name of Date of Da		Location - City or T	
altimore,	Pages nent of } snt: If Ite ury or of		1 Burial 2 Cremation 3 Removal from State		JREL MARY	
- Balti	permit. Pages Department of Important: If I eny Injury or one		21. Signature of Funeral Services Consecutive Son TEAN . D. HIBNER. Name and Address of Facility PHILI	LIPS FUNE	ERAL HOME	, P. A.
ī	do 2 o d	1.14	23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a		RE, MARY	LAND 21217 Approximate Interval Between
	Physician		shock or heart failure. List only one cause on each line.  Immedia[e/Cause (Final disease by condition a. MULTI - ORGAN FA(LURE resulting in death)			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):  SEVERE METASTATIC NICEAS	E		4 MONUMO
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
,	ate be executed nysicien and he burial-transit	Examiner	that initiated events c.  The sulfit of the			
8760,	sate be ohysicie the but	dical	d			
9 xo	nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	very
Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	230. Was deceent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month	Day Year
S,	ss that gned by	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	require	eted	ACUTE RENAL FAILURE, PROSTATE CANCER			obably 4 Unknown
Rec	The law te has t	Completed		24a. Was an autopsy performed	prior to o death?	topsy findings available completion of cause of
/ital	cian: ertifica ector, p	BeC	25. Was case referred to medical examiner? 26. Place of Death (	(Check only one)		
<b>5</b>	Physic this o	ဥ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home			cify)
ion	nding f ith. : After e funer	atlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury 28b. Time of Injury 4 North, Day Year) 28b. Time of Injury 4 North, Day Year) 28c. Injury at Work? 1 Yes 2 No	3d. Describe how in	ilary occurred	
)ivis	or Atter	Certification;	a D C Could got be	3f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
0	ospitel hours e uneral I	cal Ce	29a. Certifier (Check only    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and continuous con	nd due to the cause	e(s) and manner as	stated.
(6)	o the H ithin 24 o the F omplete	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number		Date signed (Month	
	⊢ ≯ ⊢ ŏ		DES-000	00	TOBER T	23 2009
	81		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AARTI BHATIA OD SINAL HOSPITAL OF (	BALTIM	ORE	
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature			
	Registr	ar	OCT 27 2009 Serve S. Jakes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2009 6:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlestown Retirement Community Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 K 0370371922 Maryland 87 Director 214-16-3465 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Baltimore Catonsville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR 639 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Mamied Completed by 1 ☐ Yes 2 No Specify: 3 → Widowed 4 □ Divorced If Yes, Give Year or Dates Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Accounting Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Taylor Myra McAbee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste M. Riddle (Daughter) 213 East Maple Road, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/27/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shryk, or heart failure. List only one cause on each line. Immedi te Cause (Final Onset and Death Physician/ Stage Enddisease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillati Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? tension 24a. Was an autopsy 1 Tes 2 🗌 No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122-8

DHMH 17 Rev 7/2009

State Registrar

			For State Registrar		State	of Ma			rtment of l tificate of	Health and Death	Menta	l Hygie <sub>Reg</sub>	ene . No. 20	09	34333
			1. Decedent's Name	(First, Middle	, Last)						2. Date	of Death	Day		3. Time of Death
	Physici Medio/		Josephin	ne	Ritter	hous	e I	Mac	Nemar			ber	21,20	09	10:25A <sup>M</sup>
	Examin		4a. Facility Name (If				-		4b. City, Town, c	or Location of Deat	h		4c. County	of Death	1
					are Cente				Catonsville				Balti		
	uneral irector		5. Social Security Nu 215-05-36	574	6. Sex 1 ☐ M 2 Å F	7. Age	(In yrs. last birth	- /	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date (Mo Aug	of Birth oth, Day, Y	(ear) 1917	9. Birth	place (State or Foreign intry) MD
and	M.		Usual Residence of I	Decedent 10b. County			10c. City, Town of	or Loc	ation						10d. Inside City Limits
Maryl	f sho	ò	MD	Baltin	nore		Cato						1 □ Yes 2 <b>√</b> □ No		
the	28a-	rec	10e, Street and Num						10f. Zip Code		_	100	. Citizen of V	Vhat Cou	intry?
with	3a or	Funeral Director	719 Maide	en Choi	ce Lane	BR31	2.		21228			1	U.S.A.		
death	ms 2	ner	11. Marital Status		12. Was Dec	cedent Ev		13. W	as Decedent of h	Hispanic Origin? (S	Specify Yes	or No-	14. Rac		ican Indian,
Halfially 21213-0030 2 should be filed within 72 hours after death with the Maryland 3 and Mental Horiene	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its its its and injury or other traumatic event, its its its its its of its its its in a longer.	by	1 ☐ Never Marrie 3 ☑ Widowed 4		Armed F 1 ∐Yes If Yes, G Year or	2∛∏No live			Yes, specify Cub ☐Yes 2XNo	an, Mexican, Puert Specify:	to Rican, e	tc.)	Specify Specify	k, White, Wh	etc. ite
72 ho	"natur	Completed	(Specif	15. Decedent fy only highes	's Education t grade completed	)	((	Give k	ent's Usual Occup	during most of wor	rking	16	b. Kind of Bu	usiness/Ir	ndustry
within	than	duc	Elementary/Second	dary (0-12)	College	(1-4or 5+	)		O NOT use retire tary	d)			State	of M	aryland
Filed F	other ent, t	Be C	17. Father's Name (F	First, Middle, L	_ast)				<i>y</i>	18. Mother's Nar	ne (First, i	_			alylana
id be file	Margar								ret S	. Shi	pley				
shou ond N	mar	-	19a. Informant's Nar	me/Relationsh	ip (Type. Print)		19b. N	/lailing	g Address (Street	and Number or Ru				State, Zi	ip Code)
and 2	n 27 is er tra		Mrs Marg	aret R	edford/N:	iece				h Lane Mi			e, Mar	cy1ar	nd 21108
Pages 1 anent of He	t: If iten y or oth			Cremation	3 ☐ Removal from	State	20b. Place of D	ispos	ition (Name of atory or other place Episcop	ceCem Octo	Date ober	24,	c. Location -	•	
mit. P	ortan injur e.		4 ☐ Donation 5				Ертриа		LP TDCOP	ess of Facility Sir	JU9	_ 0	dentor	i, Ma	aryland remation
permit.	any ir		MC	050	7	Mon	21			PA 1 2nd	_				
			23a. Part 1. Enter the shock, or heart	e disease, or o	complications that only one cause on	caused ti each line	he death. Do no	t ente	r the mode of dyi	ng, such as cardia	c or respira	atory arres	t,		Approximate Interval Between
	sician		Immediate Cause (F disease or condition resulting in death)		-a. Par	for	ated	١	bornel						Onset and Death
	edical miner					(or as a	consequence of)	:							2
P	.E	iner	Sequentially list conditions if any, leading to imm	ditions, nediate	bDue to	(or as a	consequence of)	:							
k, eture	and -trans	Examiner	Cause (Disease or in that initiated events resulting in death) La	ijury	C	/27.22.2	consequence of)	_							
icate be executed	physician and s the burial-transit	dicalE	,		d.	(01 43 4	consequence or								
	as th		le eeu e												
Attending Physician: The law requires that the death certifuld redeath.	by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 mm 1 □ Yes 9 □ Unknown			birth 2 gnant at t	f pregnancy  Fetal death ime of death		Ectopic pregnand Other (specify) _	cy				te of deliventh	very Day Year
that	signed b		Part II. Other signific	ant conditio	ns contributing to	death but	not resulting in the	ne und	derlying cause giv	en in Part I.	236	. Did toba	cco use cont	ribute to	the cause of death?
quires	en sig	ed by										1 ☐ Yes	2 🗌 No	3□ Pro	obably 4 Unknown
The law re	cate has been s page 2 should I	Completed										. Was an autopsy performe	<u>d</u> ?		opsy findings available ompletion of cause of
lan:	certificate ector, pag	Be C	25. Was case referre	d to medical						26. Place of Dea			Qivo	103	
hysic	.∞ ≒	10	examiner? 1 ☐ Yes	lo	Hospital: 1 □	Inpatien	t 2 🗆 ER/Outp	atient	3 □ DOA Oth	er: Nursing H	lome 5	Residenc	ce 6 □Oth	er (Spec	ify)
nding P	r: After the funeral		27. Manner o eath Natural Accident	5 ☐ Pending investiga		of Injury nth, Day,			28c. Inju	ry at			injury occurr		
tal or Atte	To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no	ned 28e. Plac	e of Injury ling, etc.	y - At home, farm (Specify)	, stree	et, factory, office		28f. Loca City	ation (Stree or Town, S	et and Numb State)	er or Rui	ral Route Number,
the Hospital or hin 24 hours afte	ne Funer	edical	29a. Certifier 1 (Check only one)	Certifying	xaminer: On the	e best of basis of e nner state	examination and/	death or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	e, and due urred at the	to the cau time, date	se(s) and ma e and place,	anner as and due	stated. to the cause(s)
To th within	To th	Me	29b. Signature and til	tle of certifier					29c. Licens	se number		29d	l. Date signe	d (Month	, Day, Year)
			myly	Co		)			D3	P89C		00	Solote	x i	2009
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		30. Name and address	Day, Year)	ter 32.	D			*	Choice !	Lan	e (	Cata	SV	ille MD
	Registra	al .	461 %	I DARGE	Lenous	-	. Charles								

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

Director

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified an once.

Maryland 21215-0036

Baltimore,

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Records,

Division of Vital

Examiner burial-transit Physician/Medical 2 page 2 should Completed Be

attending physician for use as the burial signed by the a d be detached f certificate Hospital or Attending Physician: funeral director, Certification: To After this 24 hours after death. • Funeral Director; A filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No

and manner stated.

examiner' Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier osanya

M.D

00061439

BALTIMORE MY 21215

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADETEMISI 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

Medical

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Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gordon oct. J. McKenzie Day 2009 Year 2:00pm 22 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, an. 5 219-14-5849 **X**□ M 2 □ F Months Days Hours Min. 85 Director Jan. MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Allegany MD Frostburg 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16706 Ken Lane SW 21532 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married White 1 ☐ Yes 2 🗷 No Specify. If Yes, Give Year or Dates 3 Nidowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Worker on line GM 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry McKenzie Ida Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard McKinzie /son 15034 Clark Road Stewartstown PA 17363 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans 10/27/09 Rocky Gap MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu ral Service Dicen 22. Name and Address of Facility 300 Mace Ave, Balto. MD Connelly Funeral Home of Essex 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PARKINSONS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury Due to (or as a consequence of) executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending in 24 hours after deam.
The Funeral Director: Aft Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Descripting Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific D64395 OCTOBER 22, 2009 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) 6701 NCHARLES ST, SUITE 4105 BALTIMORE, MD 21204 DANIEUE DOBERMAN, MS

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2009 34337 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Margaret 3:35AM Mover 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore N/A Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 교 F Months Days Hours Min. 98 Aug 6, **Director** 178-01-5979 1911 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madcal Evarinar must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD N/A Funeral Director Baltimore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 W. Rogers Ave. 21209 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: White 1 ☐Yes 2 ☐No ģ Specify. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lida Ash ္က Hiriam Umpelby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Moyer 27 White Pine Court Cockeysville, Maryland 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/2009 4 Donation 5 Other (Specify) Cressona Cemeterv Cressona, Pennsylvania <sup>22. Name and Address of Facility</sup> Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rady cardia **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-trai resulting in death) Last attending physician for use as the hirtel Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mort Month Year Day 5 ☐ Other (specify) 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

State Registrar

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31. Date filed (Month, Day, Year)

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Betvedere Ave Baltimne MD 21215

ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Αм Constantine John Manaras October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 D F Year) **Director** 88 235-24-2239 18. 1921 April Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County death with the Maryland Director 10c. City, Town or Location Maryland Baltimore City 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 914 East Lake Avenue 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: I frem 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Chemist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Manaras Tsouvalos Argyro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Manaras / Son 5607 Sierra Court, Mt. Airy, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Greek Orthodoc Cem. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/27/2009 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 21. Signature of Eugeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final disease or condition Onset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed?

Yes 2 No 2 🗌 No 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 A Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 2109 0 MAHMOOL 2300QULANRY

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2009 2:45m

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Ye ar **Physician** STEPHEN MADARAS 2009 22:50 M DOUGLAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD HUWARD COUNTY GENERAL COLUMBIA HOSP. GR If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 6. Se 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 🛛 M 2 🗆 F WASHINGTON, D.C. Director JUN 5 1969 218-13-5901 40 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ordant: If item 27 is marked other than "natural", or items 23a or 28a-1 show Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√XNo Director WEST FRIENDSHIP MARYLAND HOWARD CO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3495 EAST IVORY RD 21794 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No CAUCASIAN ģ Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LARRY MADARAS SR. DENISE B O'CONNELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3495 East Ivory Rd., West Friendship, Md., 21794 Darlene Young/Foster Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any Injury o BUSHY PARK CEMETERY 10-27-09 WEST FRIENDSHIP, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Signature of Funs 1206 W NORTH AVENUE 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ADULT RUSIRATORY **Physician** Hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INFLUEN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a Ö ☐Yes 2☐No 9 Unknown ٣. The law requires that 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Attending Physician: after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) -ING 31. Date filed (Month, Day, Year) 32. Registrar's State 27 Registrar

Division of Vital Records, P.O. Box 68760,

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Examin		4a. Facility Name (If not institution		BA Himo		or Location of Death	CITY	4c. County of De	eath
Funeral		SINAT HOS  5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bir	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign
Director		577-42-4783 Usual Residence of Decedent	1 <b>X</b> M 2□ F	80	Yrs. Months Days	Hours Min.	Apr. 17	7 1929 9. E	Country) VA
yland <b>how</b>		10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
he Mar 28a-f s	Director		2timore	Gwy	10f. Zip Code			0g. Citizen of What	1 □Yes 2 Mo
be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at	al Dii	3502 Tulsa	Road			1207		IJSt	4
er deat tems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI	merican Indian, nite, etc.
ours after ral", or Evenit	by	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No.	1 □Yes 2 Dolo	Specify:		Specify:	Black
72 ho "natur	leted	15. Deceder (Specify only highe	it's Education st grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of work	sing	16b. Kind of Busines	ss/Industry
d withir giene. ir than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Education Land	*		Educa	tion
be filed ntal Hy ed othe event,	Be	17. Father's Name (First, Middle,	Last)				e (First, Middle, I	Maiden Surname)	
2 should be filed within 72 he and Mental Hygiene. Is marked other than "natur aumatic event, the Medical	၉	19a Informant's Name/Relations	hip (Type. Print)	19b	o. Mailing Address (Street	t and Number or Ru	<b>Ч Д.</b> raj Route Numbei	r, City or Jown, State	e, Zip Code)
and 2 ealth a m 27 Is ner trau		Helen Neal	(Wife)	3	502 Tulsa		Gwynn	Oak, W	ID 21207
ages 1 ant of H t: If iter		20a. Method of Disposition  1 Burial 2 □ Cremation		1 8 8	f Disposition (Name of ry, crematory prother pla		Date   109	20c. Location - City	or Town, State
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev once.		4 Donation 5 Other (S		Lake	Tew Cene 22. Name and Addre		, , ,	neral Se	rvices
99 <b> </b>	- 1	Vaughn	C. Breen	ه	5151 Bul	to. Nat	1 Pilce	(21229	)
Physician		23a. Part 1. Enter t e disease, or shock, or hear failure. List Immediate Cause (Final	only one cause on each lin	ne.	•	ng, such as cardiac		est,	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequence	of):				
	ē	Sequentially list conditions, if any, leading to immediate		a consequence		art Di	sease		
s be executed sician and burial-transit	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	·					
Sur Sign	<u>a</u>	resulting in death) Last	Due to (or as	a consequence	of):				
feath certificate t attending physic for use as the b	Medic	IF FEMALE:	u.						
eath ce attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand	су		23d. Date of o	delivery Day Year
tt the d by the tached	Physician/Medic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	t time or death	3 Other (specify)				
w requires that the d been signed by the should be detached		Pertal Fail	ons contributing to death bu	ut not resulting ir	n the underlying cause given	ven in Part I.			e to the cause of death?  Probably 4 Donknown
s been should	Completed by						24a. Was a	n 24b. Were	autopsy findings available
sician: The law certificate has b irector, page 2 sl	Comp						autops perforr 1 □Yes	ned? death 2 <b>X</b> No 1 □Y	
sician certifi irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hoepital:	··· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ··	utpatient 3 DOA Oth	26. Place of Deat			
ng Phy fter this neral d	n:T	27. Manner of Death  1 Natural 5 □ Pendin	1 ☐ Inpatie	ry 28b. 1	Time of 28c. Injury Wor	ry at		ence 6 ☐ Other (S ow injury occurred	pecify)
ttendir death. stor: A	icatic	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation		M 1	]Yes 2□No	29f Logation (Ct	transformed Advantage and	Donal Books Mountain
al or A s after al Direc	Certification: To	4 ☐ Homicide determ	building, etc	c. (Specify)	rm, street, factory, office	J	City or Town		Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical (	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	f examination an	e, death occurred at the tind/or investigation, in my	ime, date and place opinion, death occur	, and due to the c red at the time, d	ause(s) and manner ate and place, and c	as stated. due to the cause(s)
To the within To the complete	Ž	29b. Signature and title of certifie	440		29c. Licens			9d. Date signed (Mo	
	-	30. Name and address of person	who completed cause of de	eath (Item 23a)		24228	(	BA 1th	1007
		Frederick J	T-BURKY IR	L,MO	SIMAI	Haspit	Al of	BAIT	more
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	arkal	,			
		Ubil		- 1					

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09-08072 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. George Nixon, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death nt's Name (First, Middle,Last) Physician/ Month Day October 17, 2009 1758 hrs **Medical Examiner** lixon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Min Director Country) 242-62-1156 Usual Residence of Decedent 10a. State 10b. County I0c, City, Town or Location 1 Yes 2 No mLwith the Maryland Director 10g. Citizen of What Country 10e. Street and Number Funeral 11. Marital Status Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? hours after death Never Married Yes 2 9 Divorced Yes, Give Year Yes 2 No specify. 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within 72 tment of Health and Mental Hygiene. d other than ", Baltimore, MD 21215-0036 ther's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number o Ry al Route Number, City or Town, State, Zip Code) If item 27 is not the traumatic Sheronda 8606 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition Burial 2 Cremation Removal from State tant: ] Donation 5 Other Specify: Signature of Funeral Service Licensee Himore Nat Physician 23a. Part I. Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Cardiac arrhythmia with bleeding from dialysis shunt vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -X UNPENDED AMENDED 23a,27,28a-f,perm,E g897 11/19/09 TT Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. rcate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? ゑ Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes After this certific funeral director, p Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 n 24 hours after death
re Funeral Director: A
letely filled in by the fu Natural bled from shunt Yes 2 X No Pending 10/17/09 11:00 am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide (Specify) house N. Catherine St Baltimore Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe O.C.M.E October 18, 2009 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT. Physician/ 22<sup>Day</sup>2009<sup>Year</sup> Samuel Noe 5:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7171 Olivia Road Middle River Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan . 30 1 🛛 M 2 🗆 F 212-58-5433 Director 58 VA Usual Residence of Decedent works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental lygiene. Fare to the result is an extend other than "natural", or items 23a larth filem 27 is marked other than "natural", or items 21a lury or other traumatic event, the Medical Examiner must b 7171 Olivia Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Completed by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired.
Superintendent 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John R. Noe Virginia Sue Engle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Noe wife 7171 Olivia Road Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State Garrison Forest 10/27/09 Baltimore MD injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SMALL CELL LUNG CANCER MONTHS METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence on if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Vear Pregnant at time of death Yes 2 No detached g 🗌 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV

DHMH 17 Rev 7/2009

State Registrar

Bott, more

21237

RD #314,

32. Registrar's Signature

PhiloDELphia

31. Date filed (Month, Day, Year

	-	For State Registrar	State	of Marylan		rtment of	Health and Death	Mental Hy	giene Reg. No. 20 (	9 34343
		Decedent's Name (First, Middle)	e, Last)					2. Date of De	ath	3. Time of Death
Physicia /Medica		Virginia,	Noble	-				October		09 03:01 am
Examine		4a. Facility Name (If not institution	n, give street and nu	ımber)			or Location of Deat	th	4c. County of	Death N/A
Funeral Director		5. Social Security Number 214-56-9780	6. Sex 1 ☐ M 2 ☐ K	7. Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th ay, Year) 7,1949	9. Birthplace (State or Foreign Country) MARYLAND
		Usual Residence of Decedent								
show	_	10a. State 10b. County		10c. City	y, Town or Loc					10d. Inside City Limits Y Yes 2 □ No
ne Ma Sa√f s	Director	MD N/	<u>A</u>		BALT	IMORE		- 1	10g. Citizen of Wh	
with t	₫	10e. Street and Number 1332 PONTIA	C ATENII	T.		10f. Zip Code	225		U.S.	
ns 23	Funeral	1332 FONTER	12. Was Dec	edent Ever in U.	S. 13. V		Hispanic Origin? (5 ban, Mexican, Puer	Specify Yes or No		- American Indian,
after o		1 ☐ Never Married 2 ☐ Marr	ied Armed F 1 □Yes If Yes, G	orces? 2X No		f Yes, specify Cu I □ Yes 2 🛣No		rto Rican, etc.)		White, etc.
within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show in the indifferent indifferent in the indifferent indifferent in the indifferent indif	d b	3 X Widowed 4 ☐ Divorced	Year or I	Dates:					Specify:	WHITE
-CI	lete	15. Decedent (Specify only highes	i's Education st grade completed,	)	(Give	lent's Usual Occ kind of work don OO NOT use retir	e durina most of wa	orking	16b. Kind of Busi	iness/Industry
within iene.	Completed	Elementary/Secondary (0-12)	College (	(1-4or 5+)	,,,,,,	HOUSEV	,		DON	MESTIC
⊒ ∉ੁਜੁ≢ ⊎	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maiden Surname,	)
baltimore, Maryland permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked o any Injury or other traumatic even once.	၉	WALTER NOE	LE				ALB	BERTA I	ELLSWIK	
Mar d 2 sho th and 7 is ma traum		19a. Informant's Name/Relations							er, City or Town, S	
e, n 1 and 1 and Health em 27 ther t		MICHAEL HAL  20a. Method of Disposition	COMB/ S	ON 20h. P				S., GLEI		E, MD. 21061
ages ant of tr. If its y or o	- 1	1 🗀 Burial 2 🔀 Cremation		i State I		sition (Name of natory or other pi רב אובר אים	ory 10/			ORE, MARYLAND
altimor mit. Pages partment of portant: If it y Injury or o	1	4 ☐ Donation 5 ☐ Other (S <sub>1</sub> 21. Signature of Funeral Service		DA.				Annual Control of the	JNERAL I	
permi Depari Impor any Ir			20/	Z	17	LLLY & 901 EAS	ZELLER STERN AV	ENUE, BA	INERAL I ALTIMORI	HOME E,MD. 21231
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death						Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition	-	vere S	epsi	S				Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a consequ	-					month
	, i	Sequentially list conditions,	b	CUMON OUTSING						more than
uted d insit	Examine	Sequentially list conditions, if any, leading to in negleto cause. Enter Underlying Cause (Disease or injury	Co	naesti		teast	Failure	2		3 years
be executed ician and burial-transit		that initiated events resulting in death) Last	Due to	(or as a consequ		t Car t				
od rou, cate be executed physician and the burial-transit	dical		d							
x ox sertific ding p	Med	IF FEMALE:	220 Hayon O	utoomo of progna	anov.		**			
BOX eath cer attendir for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna e birth 2☐ Feta gnant at time of d	Ideath 3□	Ectopic pregna Other (specify)			23d. Date Mon	of delivery th Day Year
the de check	ysic	1 □ Yes 2 Mo 9 □ Unknown	9 🗆 Unk		J. J. L.					
S that s that med b		Part II. Other significant condition	ons contributing to	death but not resu	ulting in the ur	nderlying cause	given in Part I.	23e. Did		bute to the cause of death?
ords	edk	Congestive He	art fail	lure, H	yper te	nsion,	Kneuma	10	Yes 2□No 3	3 ☐ Probably 4 ☐ Unknown
HECOLDS  ne law requires b has been sign ge 2 should be	Completed by	Fever, Chronic	: Renal	Failure	, My	ocardi	al Intarc	1120 24a. Was	psv pr	ere autopsy findings available ior to completion of cause of
The the cate h	Con	Congestive He Fever, Chronic Aortic and Mi	tral Val	ve Repla	cemer	nt, En	docardit	TS 1 □ Yes	ormed? de	eath? □Yes 2 <mark>□</mark> No
VITAI sician; Ti certificat rector, pa	Be	25. Was case referred to medical examiner?		_			26. Place of De	eath (Check only		
OT I Phys er this eral di	<u>ا</u> ي	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2  e of Injury	28b. Time of	28c. In	iury at		idence 6 Othe	
nding ath. r: Affe	ation	1 Natural 5 Pendin 2 Accident investig	9 '	nth, Day, Year)	Injury		ork? □Yes 2□No			
LIVISION I or Attending after death. Director: After d in by the fune	Certification: T	3 ☐ Suicide 6 ☐ Could leaderm	ained 28e, Plac	e of Injury - At ho ding, etc. (Specif	ome, farm, str	eet, factory, office	е	28f. Location City or To	(Street and Numbe wn, State)	r or Rural Route Number,
	Medical C	29a. Certifier 1 Certifyir (Check only one)		ne best of my kno basis of examina nner stated.	owledge, death	h occurred at the vestigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time	e cause(s) and man , date and place, a	nner as stated. nd due to the cause(s)
o the vithin 3 or the omple	Mec	29b. Signature and title of certifie		mer stated.		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
F S F O		1 Juna Mort sa	e Mil	>.		RE	S001		October.	22,2009
24		30. Name and address of person	who completed car	use of death (Iten	n 23a) (Type,	Print)				
) v		Jayzandulan	1 Natsa	3	2 Rock	ingham	Court, 1	tpartmen	to, Pari	KVILLE, MU 21234
Stat Registra		31. Date filed (Month, Day, Year)  OCT 27	<b>2009</b> 32.	Registrar's Signa	iture	arkel				kville, MD 21234

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08243 State of Maryland / Department of Health and Mental Hygiene Marcia Mary Noyes 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 23, 2009 Mary Medical Examiner Marcia Noyes 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Josephs Hospital If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Davs Hours 218-78-5586 11/09/1960 Director 48 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County s 23a or 28a-f show a notified at once. MD **Baltimore** Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10f, Zip Code 10e. Street and Number 707 Walker Avenue 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Registered Nurse 17. Father's Name (First, Middle, Last) Henry If item 27 is marked Be Mary 19a. Informant's Name/Relationship (Type, Print ) ₽ Mary Pearcr-mother 3423 Upton Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Hilltop Serv Corp 10/26/09 Donation 5 Other Specify 21. Signature of Funeral Servi - Icensee William G. 22. Name and Address of Facility Dau 1050 York Rd., Towson, MD **Physician** failure. List only one cause on each line /Medical a. Hanging Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed by the attending physician and ached for use as the burial - trans sician/Medical AMENDED UNPENDED 68760, 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box ( 1 Yes 2 No 9 ✔ Unknown Linknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P. 0. þ Completed Records, 24a Was an autopsy page ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Other<sub>4</sub> Hospital: Inpatient 2 V ER/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death FOUND: Yes 2 V No Natural Pending the Oct 23, 2009 2040 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be

2120 hrs 4c. County of Death **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or country) Maryland 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Nursing 18.Mother's Name (First, Middle, Maiden Surname) 0'Donnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD Ruck Towson Funeral Home, Inc. 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Division of Vital Nursing Home 5 Residence 6 28d. Describe how injury occurred Subject hanged self 28f. Location (Street and Number or Rural Route Number, City filled in by 3 🗸 Suicide or Town, State) 707 Walker Avenue, Towson, MD (Specify) Backyard determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. October 24, 2009 1 mel Morrie 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009	34345
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		1- For State Registrar	Ce	ertificate (				<b>200</b> eg. No.	9 3434
Physic Medical Exam	ian/ ine		neel				2. Date of Dea Month October 1		3. Time of Death 1727 hrs
		4a Facility Name (if not institution, give si Frederick Memorial Hospital	reet and number)		4b. City, Town, Frederick	or Location of De		4c. County of Death Frederick	1
Funeral Director			7. Age (In yrs.		If Under 1 Ye Months Da		0:	rth(MM/DD/YYYY) 9. Bir 14, 1943 Foreig	
w any		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
ryland a-f shov	cto	N.C. Polk  10e, Street and Number		Tryon	10f. Zip Code		. 14	0g. Citizen of What Cou	1 Yes 2 No
th the Ma 23a or 28	I Director	811 Hunting Count	ry Road			782		United Sta	,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Married 1 Vidowed 4 Divorced If N	2. Was Decedent Ever in U Armed Forces? Yes 2 X No		Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	White, etc.	can Indian, Black, White
iours aft natural" xamine	ed by	15. Decedent's Education (Specify only h	Dates:	16a. Decede	Yes 2 X N	ation (Give kind o	of work done	Specify:  16b. Kind of Business/	
036 ithin 72 h ne. r than "n Tedical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 4		nost of working lit Resource		•	U.S. Gove	nment
MD 21215-0036 11 should be filed within 7 th and Mental Hygene. 127 is marked other than umatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Patrick O'Sheel				Virgi	me (First, Middle, M nia Burt		
MD 2. 2 should h and M 27 is ma	2	19a. Informant's Name/Relationship (Type Clara O'Sheel/Wife	, Print )	19b. Mailii   811   F	ng Address (Stre Yunting (	eet and Number o	Road, Tr	yon, NC 287	Zip Code)
Ore, I		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	Place of Dispo crematory or o	sition (Name of c ther place)	emetery,	Date	20c. Location - City or	
Baltimore, ermit. Pages I an Jepartment of Hea mportant: If iter		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Moı	22.	iew Cemete	ss of Facility	tober 16, 2009	Danville,	
m ឱ្ង≝្ឋ Physician	1 15	23a. Part I. Enter the disease, or complication	M011	73 RO	bert A. P 57 Wiscon	umphrey Fu	neral Home , Bethesd	e, Bethesda-Ch a,Maryland 20	evy Chase, Inc 814
/Medical xaminer		Immediate Cause (Final disease a. Ath	ine. erosclerotic Cardiov			y, such as cardiac	or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Due  Sequentially list conditions,  b.	to (or as a consequence of	of):					
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and and transit		events resulting in death) Last Due	to (or as a consequence of	of):	-				
e ex	Medical		MENDED Item#19	bperFH,	G896,10,	/27/09,W	S		
Box 68760, death certificate by the attending physic of for use as the but		23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg Live birth Pregnant at time of de	2 Fe		Ectopic pregi	nancy	23d. Date of delivery  Month	ay Year
Box ne death the atter	Physician	1 Yes 2 No 9 Unknown	Unknown	2 □ 0	ther (Specify)				7
Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions cor	tributing to death but not r	esulting in the	underlying cause	given in Part I.		bacco use contribute to to 2 V No 3 Prob	
cords, law require has been a 2 should	Completed						24a. Was a	sy prior to c	opsy findings available ompletion of cause of
		25. Was case referred to medical			20 Div		1 Yes 2		s 2 No
Vital Physician:	To Be	examiner? 1 ✓ Yes 2 No	T IMPARETE Z		3 DOA	e of Death (Check Other A Nurs		Residence 6 Other	
ion of vertending Pheath.	ıţion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of		ury at Work? Yes 2 No	28d. Describe h	ow injury occurred	
Division of Vital Records, P.O To the Hospital or Attending Physician: The law requires that t within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detaced.	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify)	ome, farm, stre	et, factory, office	building, etc.	28f. Location (S or Town, St	treet and Number or Rurate)	al Route Number, City
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only 1 Certifying Physician:	To the best of my knowled	ge, death occu	rred at the time, d	ate and place, an	id due to the cause	e(s) and manner as state	d.
To th withir To th compl	Medical	one) 2 Medical Examiner: On and 29b, Signature and title of certifier	the basis of examination a manner stated.	nd/or investiga	tion, in my opinior		at the time, date a	and place, and due to the 29d. Date signed (Mon	
		playare meye	rele		O.C.			October 12, 2009	
15		<ol> <li>Name and address of person who comp Margarita Korell MD. Assist</li> </ol>	leted cause of death (Item ant Medical Examin	,	enn Street, B	altimore, MD	21201		
Sta Regist		31. Date filed (Month, Day Year) OCT 2 7 2009	32. Registrar's Signatu	bark	,				
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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $200^{\text{Year}}_{9}$ Oct. Day **Physician** 24 Robert Parsons 10:10a M John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7801 Kavanagh Dundalk Baltimore 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours **X**□M 2□F 217-54-0472 58 Director June 4, 1951 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 7801 Kavanagh Road USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years 3 years Instructor Disability Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Bobby Parsons Marilyn Pase 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any Injury or other traur once. 7801 Kavanagh Road, Dundalk, Maryland Cecelia Parsons wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 28, 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland onneliy füneral Ho 110 Sollers Point Home nt Rd. of Dundalk 21222 WI complications that caused the death. 23a. Part 1. Enter the disease, shock, or heart failure. Li not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-trans? Due to (or as a consequence of): Box 68760, Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Ö 1 TVes 2 TNo s been signed by the should be detached 9 Unknown ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy certificate of Vital 1 ☐Yes 2 ☐ No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital STAMO 1 ☐ Yes After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Deat Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) License number 30 Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** LIAM MICCIRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 12261 Roundwood Road Lutherville 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months 1 X M 2 □ F 217-05-6773 95 Director March 17, 1914 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at Maryland Baltimore Lutherville 1 □Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 12261 Roundwood Road U.S.A. Funeral death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1945 3 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stone Quarry Mining Entrepreneur 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked otherny injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amelia Papa Charles Piccirilli ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Piccirilli / Son 7138 Brangles Road, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2009 Baltimore, Maryland Lorraine Park 4 □ Donation 5 NOther (Specify) Entombment Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204, 22. Name and Address of Facility 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on a ach line Immediate Cause (Final disease or condition resulting in death) **Physician** un /Medical o (or s a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Exami burial-trans Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the detached i 1 □Yes 2 □ No 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? assiste Be 26. Place of Death (Check only one) 2000 Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury The Hospital or Ats.

A hours after death.

"al Director: After in by the fur After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 1 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 24,2009 ear 12:10 Am **Physician** Emily Minnie Quante-Newman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Arnold Anne Arundel Future Care Chesapeake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1-10-1930 Birthplace (State or Foreign MD Country) 7. Age (In yrs. last birthday) 79 Yrs. 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕅 F 212-26-2534 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ral", or items 23a or 28a-f show 1 √ Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 2815 Hollins Ferry Road United States Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: Specify: 3 XWidowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) al Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental H tant; If Item 27 is marked oth jury or other traumatic even Be Emma Ziemann Robert J. Quante ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr 947 Pepperwood Dr., Fayetteville, NC 28311

e of Disposition (Name of Date 20c. Location - City or Town, State <u>Steven Newman - Son</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 🖬 Burial 2 🗆 Cremation 3 🗖 Removal from State 10-28-09 Glen Haven 4☐ Conation (5 ☐ Other (Specify) Performance Park Performance Address of Facility <del>2-28-2009</del> Glen Burnie, MD Ambrose Funeral Home, Inc. 271 Hammonds Fry Rd., Lansdowne, MD 21227 Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ror as a consequence of: Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, a Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths? 3 🗆 Ectopic pregnancy Month in the past 12 proni 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed VOPUL MONARY DISCA Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b perform 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2- No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yeş this 27. Manur of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date

filed (Month, Day,

Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hugh McDonald Rodgers octobes 2009 ۱2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 04/07/1955 Months Days Hours 225-63-5288 54 Connecticut Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examination to notified at VA Mechanicsville Hanover Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8327 Old Cavalry Drive 23111 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any injury or other traumatic event, the Med one. Elementary/Secondary (0-12) College (1-4or 5+) Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald R. Rodgers Lynette McDonald ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Flippin/Sister 8327 Old Cavalry Dr., Mechanicsville, MD 23111 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State Ardent Cremation Services | 10/26/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21076 21. Signature of Funeral Service Licensee Zana C. Hardesty 7522 Connelley Drive, Ste.M, Hanover, Maryland M01197 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** momil /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 ☐ Probably 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009. who completed cause of death (Item 23a) (Type, Print State

Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Conrad Stanlev Rucker, Jr. October 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 12, 19 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Min. 1**X** M 2□ F Months Days Hours 212-52-6086 60 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2914 Westfield Avenue 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ▼ Married 1 □Xes 2 □ If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify: Specify. 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Youth Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Conrad Stanley Rucker, Sr. Joan P. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Rucker 2914 Westfield Avenue Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify) 11-3-2009 Owings Mills, Maryland Garrison Forest 21. Signative of Funeral Cervice License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Fragan 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Failurt Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pausinusins Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? end stuge reval failur 1 Yes 2 No 3 Probably 4 Unknown TCEll lymphon 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an 2 110 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical **Examiner** Examine The law requires that the death certificate be executed ical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

d other than "natural", or items 23a or 28a-f showered the frequent to rectified at

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Baltimore, Maryland

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Medical

3 ☐ Suicide

24 hours

Division of Vital Records, P.O. Box 68760

State Registrar

within 2 To the

4 ☐ Homicide 29a, Certifier

6 □ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Oyuting SMall M

00051347

29c. License number

29d. Date signed (Month, Day, Year) 10/26/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670; Nicharus It Bulhman MA 21204 Jusian UMD CYNTHIN

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 27 2009

			For State Registrar	State o	f Marylan		artment r <i>tificate</i>			d Mental	Hygien Reg. N	7 20 11 0	34351
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•	ter de ritem	Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed Fe ried 1 □Yes	orces? 2 💢 No		If Yes, speci	ty Cuban, I	Mexican, Pi	uerto Rican, e	tc.)	Black, Wi	
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ga	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Immoortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination as to citified at once.		21. Signature of June al Service	Licensee	()./					al Home	e. Inc		on, MD 21204
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			For	State of Maryla	nd / Departm	ent of Health and	Mental Hygien		
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036	be filed within 72 hours after death with the Maryland Hylgiene. All Hylgiene. Ad other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	3800 W. SE VE	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		ecedent of Hispanic Origin? specify Cuban, Mexican, Pur ss 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
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Balt	permit. Pag Department Important: any injury once.		21. Sign, up of Funeral Service Licens	gnes	1814 1814	e and Address of Acidity SNAID N. BROAD	WAY BAT	to Md a	?A 2/2/3
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_		7: To	27. Manner of Death	1 ∐ Inpatient 2	ER/Outpatient 3	DOA 4 Nursing 28c. Injury at Work?	Home 5 Residence 28d. Describe how in		ν)
Division	ospital or Attending P hours after death. Ineral Director: After t y filled in by the funera	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of injury - At building, etc. (Spe	home, farm, street, fa	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
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29b. Signature and title

of person Mag completed cause of

10/26/09
838 Greene Tree Rd 2208

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10c per fh 8896 10-27-09 vt
State of Maryland / Department of Health and Mental Hygiene 34353 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day **Physician** 5:31 AM 200 aso /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Battimore Hospital 10/HS 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-28-48 Birthplace (State or Foreign Country) 7. Age (In yrs. ast birthday) **Funeral** Days 1□M 2X F Director NA 60 Bermuda Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 22a --- any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XiX Yes 2 □ No Director Warick Warwick BO NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WK03 26 Pearmans Hill West Bermuda by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes AND Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School System 2yrs. Secretary 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Ideane Daniels Beek Place Wellington 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WKO3 26 Pearmans Hill West Warwick, Bermuda Richard Smith - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cem. Pembroke, Bermuda 10-31-09 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Literace 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner a mylaidosis Cordine Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events souther indicated events.) Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. signed by the attending I IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 MNo 24a. Was an this certificate has autopsy performed? 1 XYes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) fe. October 26, 200 9 00053368 Baltimore, MD 21287 address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital 600 N. Wolfe Street 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34354 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2009 F. Schmersal 8:05 A M Charlotte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u> Gilchrist Center</u> Towson 8. Date of Birth (Month, Day, Year) Sept 9,1938 If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Hours Min Mary land 215-36-6626 Sept Director Usual Residence of Decedent , or items 23a or 28a-f shov iminer must be notifie<u>d at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Phoenix Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21131 USA 2406 Stanwick Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ብ4 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sanner Owen Fowb1e Doris Clarence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Stanwick Road, Phoenix, Maryland Arthur H. Schmersal/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/09 Donation 5 Other (Spec Timonium, Maryland <u>Dulaney Valley Memorial Gardens</u> 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 W. Clary ryan 23a. Pan' 1. Enter the disease, or complications the shirck, or healt failure. List only one cause on Immediate Cause Final disease or condition as a. Due to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Priysician/ (ancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 2 No 1 Yes 25. Was case referred to medical of Vital Hospital or Attending Physician: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Division 1 Yes Accident Investigation Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

\*\*Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRNP R149194 October 21,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(-70) N. Charles St., Towson 21204

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's Signature

			For State Registrar	State of Marylar		rtment of F rtificate of a			giene Reg. No.	2009	3435
	Physicia		Decedent's Name (First, Middle, La	ffius Snell	-			2. Date of Dea Month Octobe	th Day 25	1.09	3. Time of Death 2:10 A M
-	/Medic Examin		Anna C. Gra: 4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death			County of Death	
	Cxamiii	GI	Stella Maris			Timon	ium			Baltimo	re
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birt (Month, Da	h v. Year)	9. Birthp	place (State or Foreign
	Director		202-22-3708	1□ M 2\\ F 82	Yrs.	WOTHING Days	Tiours Will.	Sept 1	6,19	27 Penr	rśylvania
	pu ,		Usual Residence of Decedent  10a State 10b, County	100 0	ity, Town or Lo	antion				1	0d. Inside City Limits
	aryla shov	Funeral Director	10a. State 10b. County	100. 0	•						1 ☐ Yes 2 🛣 No
	should be filed within 72 hours after death with the Maryland no Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show matic event, the Madical Examiner must be nutified at		Maryland Baltim	ore		imonium			10a Citis	zen of What Cour	atru/2
			10e. Street and Number	11 0 1		10f. Zip Code	0.2		Tog. Citiz	USA	nty:
	sath v		2300 Dulaney V	12. Was Decedent Ever in U	IS 13	Vas Decedent of H		necify Yes or No	. 1	14. Race - Americ	can Indian.
	Item Item	E	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 ☒ No		Was Decedent of H If Yes, specify Cub		o Rican, etc.)		Black, White,	
336	Irs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b> No	Specify:			Specify: Wh	ite
ŏ	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation	(-i	16b. Kir	nd of Business/In	dustry
215	hin 7 e. an "n	ble	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)				-		_	
2	d wit /gien er th	Completed	12	n/a	Act	lvities C			_	rsing Fa	acility
A . <i>M</i> . Maryland 21215-0036	be file ad oth event	Be	17. Father's Name (First, Middle, Las					ne (First, Middle,	Maiden S		
∄. <u>∨la</u>	should I and Men s marke	ျ	Frank	Mitche			Floren	11-1-1-11-11		Lozosl	
A . M Mar	S S S		19a. Informant's Name/Relationship			ng Address (Street					21220
	1 and 2 Health (em 27 is		William R. Graff 20a, Method of Disposition			Holly Hu		Date		cation - City or To	
7:	Pages Inent of International		4 D Burial D D Commetters O I	Removal from State	cemetery, crei	sition (Name of natory or other pla	ce)			•	
Z:10 Baltimore,	t. Pa rtmer rtant: njury		4 □ Donation 5 ☒ Other (Spec	AH -							
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Spature of Full et al. Service Liv.  Bryan W. C1	ary	1	2. Name and Addre Lemmon Fu 10 W. Pad	onia Roa	d, Timon	ium,	y Valley MD 210	y Inc. 093
			23a. Part1. Enter the disease, or conshock, or heart fillure. List only	npli ations that co sed the dea	th. Do not en	er the mode of dyi	ng, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	İ	Immediate Cause (Final disease or condition resulting in disease)	GNIS ST	74GE	DEME	NTIA			1	Oriset una Beatif
	/Medical Examiner	Examiner	resulting in docting	Due to (or as a conse	quence of):						
			Sequentially list conditions,	uentially list conditions, y, leading to immediate se. Enter Underlying et la training to initiate events c.							
	ted		cause. Enter Underlying								
$^{z}/h$	Secural and al-tra	xar	that initiated events resulting in death) Last  C. Due to (or as a consequence of):								
68760	ificate be executed physician and as the burial-transit										
, ,	ficate physics the	Physician/Medical		u			_				
25	eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy	<b>7</b>			2	23d. Date of deliv	ery
	death e atte d for		in the past 12 months? 1 \( \sum \) Yes 2 \( \sum \) No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _				Month	Day Year
P.O.	that the de ned by the a	hys	9 Unknown	9 🗌 Unknown					- 1		
OCTOBER IS. P.O. E	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use s	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t		2	he cause of death?
S	equire en siç ould b								1 ☐ Yes 2 📉 No 3 ☐ Proba		bably 4 Unknow
ر Record	e law re has be	Completed						24a. Was		24b. Were auto	opsy findings available empletion of cause of
	The l							perfo	rmed? 2 Dayo	death?	
Vital	ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)		
VELL of V	Physician: r this certific ral director, I		1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatie		4 Mursing I	lome 5 Resi	dence 6	6 □ Other (Speci	fy)
	ng P	ü.:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o	Wor		28d. Describe	how injury	y occurred	
ß Sio	Vttendi death. ctor: A y the fu	cati	Accident investigation  3 Suicide 6 Could not	he -			Yes 2 □ No	0011 11 11			10 . 11 .
ANNA S. Division	or Attending after death. I Director: After d in by the fune	Certification: To	4 Homicide determine		nome, farm, st cify)	eet, factory, office		City or To	Street and vn, State,	d Number or Rur )	ai Houte Number,
· 4 🚨	Hospital 24 hours a Funeral I		29a. Certifier 1 CertifyIng F	Physician: To the best of my kr	nowledge, dea	h occurred at the t	ime, date and plac	e, and due to the	cause(s)	) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Excore)	miner: On the basis of examir	ation and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and	place, and due	to the cause(s)
	<b>To the</b> within 2 <b>To the</b> соттріе	Me	29b. Signature and title of certifier	E PRACTITIONER		29c. Licens	se number		29d. Dat	te signed (Month,	Day, Year)
	F S F O		> Silling 1	ANP		RIU	9797		10	12/2/20	09
	3		30. Name and address of person wh	o completed cause of death (ite	em 23a) (Type.	Print)	1116			100/00	~ <u> </u>
	2		JACKIE JONES,			ALLEY ROA	D TIMON.	IUM, MD	2109	3	
	Sta	te	31. Date filed (Weath Day 1997)	32. Registrar's Sign	nature _						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year C7:05 PM Catherine E. Seay october 23 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital of Sinau Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 9, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2√2 F 212-09-7380 91 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Cole Lane 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No Specify: Specify: White 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen J. Thomas Lillian E. Rode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Cohen /daughter 532 Cole Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 10/27/09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Cornel Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or any dications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List the property of the death of the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Perstonila Due to (or as a consequence of): Disease Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bex tension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Examiner** law requires that the death certificate be exect Box 68760. P.0. Division of Vital Records, Hospital or Attending Physician: The

and burial-tra attending physician the as nse jo signed by the a page 2 should has certificate n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

Medical

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Experience must be notified at

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, III

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Seay, Cathresine

New

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within 24 hor To the Fune completely fi

Htrial f	bullation		24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings availabl prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
25. Was case referred to medical examiner?		Check only one)					
1 Yes 2 Do	Hospital: 1 patient 2 ER/Outpatient 3	Other (Specify)					
27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio		28c. Injury at Work? 1 □ Yes 2 □ No	d. Describe how injury	occurred			
3 Suicide 6 Could not b 4 Homicide determined		ctory, office 28	f. Location (Street and City or Town, State)	l Number or Rural Route Number,			
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and place, and due to the and manner stated.							
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)				

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19620

29d. Date signed (Month, Day, Year) october, 23 2009

MBBS

2401 W. Belverlovetu, of Baltemore KAPOOR, SINCU SUMIT Baltimore, MD 21215 31. Date filed (Month, Day, Year)

			For State	State of Maryla	-	rtment of tificate of		Mental Hy	giene Reg. No. 2	009	3435
			Decedent's Name (First, Middle, Last	)			Douili	2. Date of De	ath		3. Time of Death
			DONALD ERN	EST SHI	ELDON			OCTOBEI	R 16, 2		5:30 P M
1			4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	1		3. Time of Death 009 5:30 P M by of Death ORD  9. Birthplace (State or Foreign Country) New York  10d. Inside City Limits 1	
-			BRIGHTVIEW ASSI			BEL AI					
	Funeral		1[	Orm 2□F	s. last birthday) Yrs.	If Under 1 Year Months Days		(Month, Da		Cour	itry)
		•	Usual Residence of Decedent	}	31 ''s.			Oct. 20	5, 1927	<u>New</u>	York
	ylanc how	_	10a. State 10b. County	10c. 0	City, Town or Loc	ation				1	
	e Ma 8a-f s	cto	New Jersey Union	Sc	cotch Pl	ains					1 □ Yes 2 □ No
	vith th					10f. Zip Code				What Cour	ntry?
	eath v	eral	321 Accacia Ro	ad 12. Was Decedent Ever in	11S 12 M	0707		pecify Ves or No	USA	aco - Amorio	ean Indian
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Exercines roust be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:		Yes, specify Cu	f Hispanic Origin? (S iban, Mexican, Puert o Specify:	o Rican, etc.)		ack, White,	etc.
2-0	72 hou	State   Chysician   Medical	15. Decedent's Edu	Education 16a. Dece		ent's Usual Occ	upation	kina	16b. Kind of		
21	ithin 7	nple		College (1-4or 5+)	l		e during most of wor red)	Kirig			
7	led w tygier her th	ပိ	47 F. H. J. N. J. (First Addition Land)	5+	Admini	strator		(First Mistella			
Baltimore, Maryland 2121	the find the ed of ced of cever			n				• McGler		ime)	
Z	should be ind Mental marked c	ĭ	19a. Informant's Name/Relationship (T		19b. Mailine	a Address (Stree	-			n. State. Zin	Code)
No.	1 and 2 s Health au tem 27 is		Lyle E. Sheldon /	•		,					,
ē,	e H H		20a. Method of Disposition	20b.	Place of Dispos			Date			
Ē	Page nent o		1 ☐ Burial 2 【A Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	removal from State			Corp. 10-2	27-09	Towson	Mars	zl and
alti	ppartr porta ny Inju		21. Signature of Funeral Service Livens	ee	2 <del>2</del>	Name and Add	Funeral H	ome, P.A		, mar	7 ± 011 0
<u>—</u>	90F # 9		Hally I I'll	nasteu	1	317 Cok	esbury Ro	ad, Abir	ngdon, 1	Maryla	
	Physician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	<i>)</i> .		ying, such as cardiac				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		-//	ZVI CI III	,			ic years
	Examiner	L	Sequentially list conditions	b							
Q.	ed sit	ine	if any, leading to immediate Due to (or as a consequence of):  Cause. Enter Underlying  Cause (Disease or follow)								
NZO	ficate be executed physician and s the burial-transit	xan	that initiated events	c Due to (or as a conse	equence of):		·-				
68760, Kg	e be e sician buria	alE		4							
687	ifficate g phy. as the	edic		d							
Вох	Attending Physician: The law requires that the death certi refeath.  redeath.  sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	M/m	23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregna			23d. D	ate of delive	эгу
	deat he att ed for	sicia	1 ☐ Yes 2 ☐ No	4 Pregnant at time o		Other (specify)			1	/lonth	Day Year
P.0	at the	Phy						00 011		16, 2009   5:30 P	
3,	res the signeral libe d	by	Part II. Other significant conditions co	ntributing to death but not re	esuiting in the un	derlying cause g	given in Part I.	23e. Did	. 4		
Ö	requi	mpleted									
Sec	has I							24a. Was	psv	prior to co	psy findings available mpletion of cause of
<u>a</u>	n: Th ficate n, pag		OF Mos some referred to medical						2 No		2 □ No
Ξ	s certi		examiner?	Hospital: 1 ☐ Inpatient 2	 ☐ ER/Outpatient	2 D D O	26. Place of Dea			Aban (0	Accieted
of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inj				- ' '	
io	ath. r: Aft	atio	2 ☐ Accident investigation	(Month, Day, Year)	Injury		ork? □Yes 2□No				
Division of Vital Records,	tal or Atters after de al Directo	Certific	determined   200. Flace of stiguty - At Hottle, lattit, street, lactory, office   201. Location						(Street and Number or Rural Route Number, own, State)		
	n 24 hour ne Funer		(Check only 2 Medical Exam								
	To th withii To th comp	Me	29b. Signature and title of certific			29c. Lice	nse number		29d. Date sign	ned (Month,	Day, Year)
				~D		1	0 35 0/		10/1	9/2	2009
	1.		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type, F	Print)	maphail	1.1	12014	- M	1. 2/1/4
	- +			32. Registrar's Sign	© /.	2 00,1	12/11-1/	104,	2977	, , , , , ,	21014
	Sta		31. Date fill Canth Day 2009	Cherry 3.	parke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2009 ANN LOUISE STEIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedale Franklin Mare 8. Date of Birth

(Month, Day, Year)

JULY 18,1920 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min <sup>C</sup>MARYLAND 1 □ M 2 Ϊ XF 89 220-24-9688 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director BALTIMORE ESSEX MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21221 30 WALKERN ROAD Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. I ☐ Yes 2**X** No f Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes XXNo Specify: WHITE 3 X Widowed 4 ☐ Divorced þ Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLARA LaDUKE WILLIAM SESSAMEN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15 OAKWOOD DRIVE, DELTA, PA MARY K. THOMMEN/ DAUGHTER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND BAYVIEW CREMATORY 10/26/09 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 21. Signature of Fun 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician Kenal /Medical resulting in death) Due to (or as a consequence of) Examiner Failure ongestive Eustrie (er as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed schemic that initiated events resulting in death) Last and burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death ned by the atter Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be der 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury at Work? 27. Manner of Death Certification: eral Director: After filled in by the funera Injury 1X Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

4 State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Adnan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Choudhu

29c. License number

RESOOOO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009

		For State C  State C Registrar	of Maryland 7	Depar Certi	tment of H ficate of D	ealth and eath	l Mental Hyç ا	giene , <sub>Reg. No.</sub> "	2009	3435
Physicia		1. Decedent's Name (First, Middle, Last)	Peter Seoa Seoane	ne Jr	•		2. Date of Dea October		2009	3. Time of Death 5:37 a
Medi Examir		4a. Facility Name (if not institution, give street and nur Gilchrist	nber)	4	b. City, Town, or Towson	Location of Dea	ath	4c. C	Baltimo	
Funeral Director		5. Social Security Number 380−28−2723 6. Sex 1X□ M 2 □ F	7. Age (In yrs. last bi		f Under 1 Year Ionths Days	If Under 24 H Hours Mi		h , Ye <b>q</b> r.92	9. Birti	nplace (State or Foreig ntry) Orida
e Maryland r 28a-f show notified at	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimore  10e. Street and Number	10c. City, Tov		ion 10f. Zip Code			10a Citiz	en of What Co	10d. Inside City Limit  1 ☐ Yes 2 1
<b>Baltimore, Maryland 21213-0030</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		206 Deerfox Lane  11. Marital Status  12. Was Dec Armed Formation of the Company	2 No ve vates.	1 [	2109	spanic Origin? I, Mexican, Pue Specify:	Specify Yes or No- erto Rican, etc.)	1 s	JSA  4. Race - Amer Black, White pecify White	ican Indian, , etc.
vithin 72 hadiene.		(Specify only highest grade completed	1) 1-4 or 5+) 1-5	(Give kir life. DO	d of work done d NOT use retired) Preside	uring most of w	vorking		per Com	
Maryland  2 should be filed v  Ith and Mental Hyg  27 is marked oth  traumatic event,	To Be	17. Father's Name (First, Middle, Last) Peter	Seoane			18. Mother's N	lame (First, Middle,	Maiden Si	urname) Gonza	lez
re, Mary 1 and 2 shoul f Health and I item 27 is m other traums		19a. Informant's Name/Relationship (Type, Print)  Mrs. Margaret Seoane/ W  20a. Method of Disposition	20b. Place	of Disposit	Address (Street a Deer fo) ion (Name of tory or other place	- !	Rural Route Numbe Timonium, Date		21093 cation - City or	
<b>Baltimore,</b> permit. Page 1 and Department of Hes Important: If item any injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fulf-fral Service Upensee		op Se	rvice Co	o. 10 sਾਰਿਲਾ∰ਨਾn	-30-09 Funeral d. Towson	Home	wson, M , Inc. . 21204	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or page 2.		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	ach line.	- <i>SOF</i> e of): ∘ ∪∫:			RCOMA			Approximate Interval Betweer Onset and Death
. Box 687  le death certification the attending properties as	pleted by Physician/M	in the post 12 months?	utcome of pregnancy Birth 2  Fetal de- gnant at time of death known		Ectopic pregnand Other (specify)	у		2	3d. Date of del	ivery Day Year
ords, P.O. By requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to CORONARY ARTERY DIATRIAL FIBRILLATION		ng in the un	derlying cause giv	en in Part I.				the cause of death
HeCOK The law req ate has bee page 2 shot		ATRIAL FIBRILLATION	N				24a. Was auto perfo		prior to death?	topsy findings avail completion of cause 2
Vital ysician: s certifica		25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	Inpatient 2 ER/	Outpatient	Oth		Check only one) g Home 5 □ Resi	dence 6	Other (Spec	ity) HOSPI
Division of Vital Records, tal or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be a laborate.		1 Natural 5 Pending (Mo	e of injury nth, Day, Year)	o. Time of injury	28c. Injun work M 1	/ at	28d. Describe l			
To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page		4 Homiciae determined build	e of Injury - At home, ding, etc. (Specify)				City or Tov	vn, State)		ral Route Number,
he Hospit in 24 hour he Funera	Medical	29a. Certifier (Check 2 Medical Examiner: On the bonly one) 3 Certifying Nurse Practioner	asis of examination and	d/or investig	ation, in my opinio ath occurred at th	on, death occurr e time, date and	ed at the time, date a	and place, ne cause(s)	and due to the and manner as	stated.
with to		29b. Signature and title of certifier	7		29c. License	1395	-		e signed (Monti	h, Day, Year) 26 / 2009
		30. Name and address of person who completed car DANIEUE DOBERMA	N. MD 67	201 N	CHARLES	STI 84	UTE 4105	BA	LTIMERE	, MD 2121
St	ate	31. Date filed (Month, Day, Year)	Registrar's Signature	books	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 2.29d ber done 10-2709 at Hygiene
State of Maryland / Department of Health and Mental Hygiene
amend #5 per FH G896 10/27/09 JH
Reg. No. 2009 34360 1, Decedent's Name (First, Middle, Last) 2. Date of Beath Month OCT Physician/ RONALD LE-10PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CITY HEALTH + REHAR ELLICOTT ELLICOTT HOWARD If Under 1 Year If Under 24 Hrs. 5. Social Security Number IInk 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min Country)
MARY Director JANUARY 10, 1964 Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Tes 2 No BALTIMORE WINDSOR MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SIX COURT POINT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏿 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE SCHOOL BUS DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SPRIGGS RONALD CAROLYN HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPRIGGS TOWANDA POINT WINDSOR MILL, MARYLAND 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 10/09/2009 LANSDOWNE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL HOME SOSEPH 2140 N. lam FULTON AVE, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Acquired Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): de Examiner acral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မူ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this d in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by: 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RG MESh Sabanas M' 201-165 BECK Rever Neck Lecal 31. Date filed (Month, Day, 32. Registrar's State Registrar

Amend #14, per Fh g897 1175/09 TT State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1406 M **Physician** 1. Serota 22 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) June 30, 1961 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Massachusetts 48 029-50-8226 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No by Funeral Director PA Wilkes-Barre Luzerne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or U.S.A. 18702 2 Edison Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc.
White 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced **Black** Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Laborer Finance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Rosalie Serota 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurelle Serota Edison Street Wilkes-Barre, PA 18702 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Secrify) Date Maple Hill Cemetery 10-29-2009 Hanover Township, PA Donation \_5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Foneral Service Licensee Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non-Ischemic Cardiomyopathi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760; by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) pital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
Injury
28c Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Medical Doctor NPI 1104051945 10/22/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltmore, MD 2/201 Elizabeth K .Smelter S.

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day,

park

32. Registrar's Signature

		For		State of Ma	ırylanı		partment of I		ınd Mer	าtal Hyg	giene	000	21.20
		_ State Registrar				C	Certificate of	Death			Reg. No.	009	34362
Physicia		1. Decedent's Name Mario	e (First, Middle, Li n Ethel	,						Date of Dea 001124 -		Year Year	3. Time of Death 1:40 P M
/Medica Examine	_	4a. Facility Name (I	lf not institution, gi	ve street and number)			4b. City, Town, o	or Location of	f Death		4c. Cc	unty of Death	
				Center			11.11.11.11	minst				Carro	
Funeral Director		5. Social Security N 219-14-			86 (In yrs. li	a <i>st birtho</i> Yrs	Months Days		Min.	Date of Birtl (Month, Day 2 – 2 7 –	, Year)	Coui	place <i>(State or Foreigi</i> ntry) vland
		Usual Residence of			10- Cit	. Taura a	r Location						10d. Inside City Limits
r 28a-f show	tor	10a. State MD	10b. County Car:	roll	roc. City	, IOWII O	Mt.	Airy					1 □ Yes 2 <sup>1</sup> No
th with the 23a or 28a	al Director	10e. Street and Nur		Cindy Rd.			10f. Zip Code	2177	1		-	of What Cour JSA	ntry?
	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ied 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give		3.	13. Was Decedent of If Yes, specify Cub		gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		Race - Americ Black, White, pecify: wh	etc.
2 hour			15. Decedent's E		- 0	16a. D	ecedent's Usual Occu	pation	-6		16b. Kind	of Business/In	dustry
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ges 1 and 2 should be filed within 73 it of Health and Mental Hygiene. If Item 27 is marked other than "n or other traumatic event, It. Media	10 Be	17. Father's Name		Thomas H	ymi]	ller				irst, Middle, Bown		rname)	
nd 2 shou aith and N 27 is mai r trauma		19a. Informant's Na Kevin S	ame/Relationship			1	lailing Address (Stree						o Code)
of Hea		20a. Method of Dis	•	75 44 64	20b. Pl	lace of Di emetery,	sposition (Name of crematory or other pla	ice)	Date		20c. Loca	tion - City or To	own, State
Pages Iment of tant: If it jury or o			☐ Cremation 3 L 5 ☐ Other (Spec	Removal from State	l		Grove Cen	n. '	10-28	-09		Airy,	
permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tr once.		21. Signature of Fu	uneral Service Lice	Flitten.	111	-	22. Name and Addr						
Physician /Medical Examiner	Examiner	23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list conif any, leading to im- cause. Enter Unde Cause, Obsease or	ert failure. List only (Final on	nplications that caused y one cause on each lin  a.  Due to ( or as a Due to (or as a	ne. Ma consequ	ience of):	enter the mode of dy	lase	cardiac or re	espiratory ar	rest,	u	Approximate Interval Between Onset and Death
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the dea	Pnysician/M	in the past 12 1 ☐ Yes 2 9 ☐ Unknown		4 ☐ Pregnant at 9 ☐ Unknown			5 ☐ Other (specify)					Month	Day Year
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an: T tifficat tor, pa	a)	25. Was case refer	red to medical	T				26. Place	of Death (C	1 □ Yes Theck only o		1 ☐ Yes	2 ∐No
yslcl nis cen direc	0	examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpa	atient 3 DOA Ot	hor:				Other (Speci	ify)
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e Hospita 124 hours e Funera ietely fille	edical	29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	Physician: To the best of the miner: On the basis of and manner sta	examinal	wledge, o	leath occurred at the or investigation, in my	time, date an opinion, deat	d place, and th occurred	due to the at the time,	cause(s) a date and p	nd manner as ace, and due t	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and					29c. Licen	se number				signed (Month,	
		16/2	hm W.	midde	ton		DZ	544	5		101	26/2	009

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Westminster, MD 21157

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 2 Year imolhi I hom DSC : OSPM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death altimore 6-leu Burnie washington Medica 7. Age (In yrs. last birthday)
57 yrs If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Months Days Hours Min. Ju<sup>(Month</sup>, 1<sup>Pay, Year)</sup> 952 Mary Tand 219-54-2903 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b, County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1401 Gordon Drive 21061 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 M Divorced Completed White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive/HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur R. Thompson Thelma C. Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Thompson / Brother 6207 Woodland Rd., Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October o Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Pk. 4 Donation 5 Other (Specify) 2009 Elkridge, Maryland 21. Signal re of Forts at Servi ALicensee 22.Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death. Physician/ disease or condition resulting in death) Taph Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No ed by the a detached f 9 Unknown 9 Unknown הי היוווים איווורים ליהוווים ליהוווים ליהוווים ליהוווים ליהווים rt II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Bipcla 1 ☐ Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Anpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniurv 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Corriging Nurse Practioner To the basis of my knowledge, and in course at the time, cate and place and due to the cause(c) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 24 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CL 31. Date filed (Month, Day, 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THOMAS **Physician** BER OCTOBER 200 6:30 AM /Medical 4a. Facility Name (If not institution, give street and number) n, or Location of Death Examiner HOSPITAL SECOURS It more 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State gr Foreign **Funeral** Months **M** 2□ F Davs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Logation show 1XYes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Cou 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic event, the Madical Evanding Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT up 1957ed ondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden St n and Mental H ည 19b. Mailing Address (Streat and Number of Gural Route Number 19a. Informant's Name/Relationship (Type. Print) of Health a 20a. Method of Disposition Place of Disposition (Name of cemetery, or ematory or other ō Department of Important: If it any Injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2140 N. Froten 2%a. P. 11. Enter W. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nock, or hard failure. List only one cause on each line.

In rediate Cause (Final sease or condition resulting in death) Physician NEUMONIA /Medical Due to (or as a consequence of): Examiner CEMIA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed RENAL FAILURE Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 □ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 ∏No 2 Accident 1 TYes Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

KOSITA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

KO

14.3 Registrar's Signature

BON SECQUES

29c. License number

00030355

29d. Date signed (Month, Day, Year)

OCTOBER 21, 2009

			Please	Type or Prin				-	_	
			For State Registrar	tate of Ma	-	partment of l e <i>rtificate of l</i>		Mental Hygie	ene 2009	34365
	Physicia Medic		1. Decedent's Name (First, Middle, Las	TURNE	R			2. Date of Death	20, 2009	3. Time of Death 7:26 9 M
	Examin		4a. Facility Name (if not institution, give 2707 DelK (5	street and number)			or Location of Death	1	4c. County of Deat	more
	Funeral Director		5. Social Security Number 6. S	ex M 2 □ F 7. Age (	In yrs. last birthday Yrs.			8. Date of Birth	9. Birl	thplace (State or Foreign untry)
	ind show at	'n	Usual Residence of Decedent  10a. State 10b. County		10c City, Town or	Location				10d. Inside City Limits
	e Maryla r 28a-f s notified	Director	MD Baltin	nore	Duno	10f. Zip Code		Lac		1 🗆 Yes 2 📉 No
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	2707 DelK (	Court			222	100	g. Citizen of What Co	
ဖွ	ter deatl or item miner n	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 2 Yes 2 1 N	er in U.S. 13	3. Was Decedent of H If Yes, specify Cub		pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	e, etc.
-003	hours af natural" ical Exe	leted	3 Widowed 4 Divorced  15. Decedent's E	If Yes, Give Year or Dates. ducation	16a. Dec	1 ☐ Yes 2 💆 No cedent's Usual Occup		16	Specify: 8	ack
21215-0036	ithin 72 ene. • than "r he Med	Completed	(Specify only highest grant   Specify only hi	College (1-4 or 5+)	(Giv	re kind of work done DO NOT use retired,	during most of world	king	Naux	<i>t</i> .
	e filed w Ital Hygi ed other event, t	To Be (	17. Father's Name (First, Middle, Last)	UNK	11/02	a Chia		ne (First, Middle, Mai	den Surname). U	ıĸ
Maryland	should be filed within and Mental Hygiene. is marked other tha aumatic event, the N		24a. Informant's Name/Relationship (7)	vpe, Print)	19b. Ma	iling Andress (Street	and Number or Rui	ral Route Number, Ci	ty o Town, State, Zip	Code)
	and 2 s Health tem 27		Kodney H. lurn  20a. Method of Disposition	er (Son).	791 20b. Place of Dis	8 tebble	Brooke	Ct, Sprin	ghield, V	A 22/53 Town State
Baltimore,	Page nent o ant: If ıry or		1	ý)	Arlingt	ematory or bither pla		7,2010	Arlington	VA
Ba	permit. Page Departmer Important any injury once.		21. Signature of Funeral Service Licens	Greene	-	22. Vaught 5151 Ba	sseriere Ha. Nat	ere ture	ral Ser (21229	vices
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	Physician/ Medical Examiner		disease or condition resulting in death)	a	consequence of):	9 M	1700 118	~		
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):					
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k 68760	eath certificate b attending physi I for use as the b	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	☐ Ectopic pregnan	CV		23d. Date of del	ivery
Box .	that the death ned by the att detached for	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown		Other (specify)			Month	Day Year
, P.O.	es that t signed b be deta		Part II. Other significant conditions of	ontributing to death but	not resulting in the	e underlying cause gi	iven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords	w requires these these responsibles to should be considered.	Completed by						24a. Was an	24b. Were au	topsy findings available completion of cause of
of Vital Records,	sician: The law i certificate has b irector, page 2 s		25. Was case referred to medical		-				d? death?	2 No
Vita	Physician: this certific al director,	To Be	examiner? 1  Yes 2 No	Hospital: 1  lnpatien	t 2 ER/Outpat	Oth	Place of Death <i>(Ched</i> ner: 4  Nursing H	ome 5 Residence	e 6 Other (Spec	ify)
on of	nding Pt ath. :: After th e funeral	icate:	27. Manner of D ath  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	(28b. Time injury	wor	ryat k? ]Yes 2 □ No	28d. Describe how i	njury occurred	
Division	Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physted filled in by the funeral director, page 2 should be detached for use as the	Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (		street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After it completed filled in by the funeral	Medical	(Check *2 \(\sum \) Medical Exami	sician: To the best of miner: On the basis of exa	mination and/or inv	estigation, in my opini	ion, death occurred a	at the time, date and p	lace, and due to the o	ause(s) and manner stated.
_	To the Comp	2	29b. Signature and title of certifier	- Consider to the be	as of my knowledge	29c. Licens	se number	29d	. Date signed (Month	
			30. Name and address of person who o	completed cause of dea	th (Item 23a) (Type	, Print) 8	1808 1AN	many o	n 875	128
	Stat	6	31. Date filed (Month, Day, Year)	L Kun	Signature	mo	9 600	man.	3 my	21061
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State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Ye ar Harvey L. Weterner 0324 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Yrs. Director 337-01-5597 94 North Dakota 05-15-1915 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Madical Experiment and be notified at 1 ☐Yes 2 👿 No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Pages 1 and 2 should be filed within 72 hours after death with 2400 Chestnut Terrace Ct. #204 Funeral 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Was Decedent Ewa Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 X No 2 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene, Industrial Engineer United States Navy is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Waterman Elizabeth Mae Schoener 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Myrtle Waterman / Wife 2400 Chestnut Terrace Ct. #204 Odenton, MD 21113 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 10-27-2009 W. Odenton, Maryland 21. Signatura o Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 art 1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Die to (or as a consequence of) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 █ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the f 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/26/2001 -000 LUS 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 che. me Arunde

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Đay, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

Division of Vital

32. Egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $8:30 a^{M}$ October 23, 2009 ELIZABETH PRITCHARD WELSH HELEN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 15617 Bond Mill Road Laurel Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2√₹ 12, 1918 91 March Maryland 217-14-7007 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, its Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 15617 Bond Mill Road 20707 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIII o If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ∐ Ye*s* 2**X** No Specify Specify: White \$ 3 XXVidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be t Health and Mental Helen Elizabeth Beall Charles Elmer Pritchard ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15611 Bond Mill Road Laurel, Maryland 20707 James L. Welsh, Jr. / son injury or other altimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages ' permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2XX remation 3 ☐ Removal from State W. Arundel Crematory 10/24/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonanadones Funeral Home, P.A. M00770 20707 313 Talbott Avenue Laurel, Maryland te or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ust only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician Acute Renal Failure 3 weeks /Medical Due to (or as a consequence of): **Examiner** Hypovolemia 4 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No the detached 9 ☐ Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Hypertension page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🗓 🗀 🗀 1 □ Yes 2 □XNX 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 X Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ X1X0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dea... ral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 23, 2009 D43237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D. 14201 Laurel Park Drive, Suite 102, Laurel, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 2

Bankon

		For State of Maryland / Dep State Registrar Ce	artment of Health and N <i>rtificate of Death</i>	lental Hyglel Reg.	
Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Medic	al	Betsy Schmitz Weige  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October_	Day Year 25 2009 8:34 A M 4c. County of Death
Examin	er	3883 Shamrock Court	Port Republic		Calvert
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Mar 9, 19	9. Birthplace (State or Foreign
Director		216-28-9818		Mar 9, 19	114 Maryland
yland f shoved at	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
ne Mar nr 28a- notifi	Direc	Maryland   Calvert County   Port F	Republic 10f. Zip Code	100	1 ☐ Yes 2 💢 No  Citizen of What Country?
with the 23a c	Funeral Director	3883 Shamrock Court	20676	Tog.	USA
death items	Fun	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by	1 Never Mamied 2 Married  3 M Widowed 4 Divorced  1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🌠 No Specify:		Specify: White
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of worki	ina 16t	b. Kind of Business Industry
tthin 7	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	OO NOT use retired)		Parish Administration
filed wall Hygin other vent, t	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
Marylan Should be file h and Mental 7 is marked of traumatic eve	욘	William Joseph Schmitz	Estel:	le	Hebner
Mar 2 shou th and 27 is rr traum	1	/ I	ing Address (Street and Number or Rura		
ge 1 and to Troit Healt If item 2 or other		20a. Method of Disposition 20b. Place of Disp	osition (Name of		olic, Maryland 20676  c. Location - City or Town, State
Fage 1			matory or other place) edral Cemetery 10/	28/09 Ba	altimore, Maryland
Baltimore, I permit, Page 1 and 2 Department of Healt Important; If item 2 any injury or other once.		21. Signal o Funda S selic s R	TICHELL WIEDEFELD 500 York Road, Bal		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate
Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	- Heart la	·lure	Onset and Death
Examiner		Due to (or as a consequence of):	- Iteart Fa	vaccula	Disease
	Examiner	Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying			
ecutec and -transi	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last			
68760 Sq. certificate be executed nding physician and use as the burial-transit	edical	d.			
68760 certificate b ding physicse as the b		IF FEMALE:			
	Physician/M	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
O. Bo	hysi	1   Yes 2   4   Pregnant at time of death 5   9   Unknown 9   Unknown			
J. T. B. B. B.	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
rds require seen si hould	eted				2. Solo 3 Probably 4 Unknown
<b>/ital Reco</b> stcian: The law i certificate has b	Completed			24a. Was an autopsy performed	
an: Th an: Th tifficate tor, pa	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check	1 Yes 2	No 1 Yes 2 No
hystol	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 Residence	e 6 Other (Specify)
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	27. Manner of Death  28a. Date of injury (Month, Day, Year)  28b. Time of injury (Month, Day, Year)	of 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
Atten er dear ector: by the	artifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st			t and Number or Rural Route Number,
Div nital or urs afte ral Dir lled in		building, etc. (Specify)		City or Town, St	
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or inversionly one)  3 Certifying Nurse Practioner: To the basis of my knowledge, death	stigation, in my opinion, death occurred at	the time, date and pl	ace, and due to the cause(s) and manner stated.
To th Withir To th COTE	=	29b. Signature and title of confiner	29c. License number		Date signed (Month, Day, Year)
		· //// C/MD	1 033123		10-26-09
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Jonathan Lowenthal, M.D., 10845 Town	· ·	ite 204. I	Ounkirk. MD 20754
Sta		31 Date filed (Month / Mar) Year) 32 P giotrario Signaturo A	haves		
Registra	air	1101 27 2000 B. 13			

09-08129 Michael Anthony Wh	Please Type or Print in Black Indelible Ink. E State of Maryland / Department of Hea	nsure All Copies Are Legib Ith and Mental Hygiene	
1	- For State Certificate of Dea	th Reg. N	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  Michael Anthony Whitloc	2. Date of Death Month Da October 19, 2	3. Time of Death 2325 hrs 4c. County of Death
s.	Tall a control to the the the tall and the t	Town, or Location of Death	Prince George's
	2234 Brightseat (Vad #302		MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	229-82-1725 1 M 2 F 53 Yrs. Mon	1 14 14	1956 Foreign Country) CA.
any	Usual Residence of Decedent  10a. State		10d. Inside City Limits
V 1	MN P.G. Itrattovil	e	1 Yes 2 KNo
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Toe. Street and Number	70 785	Citizen of What Country?
th the 23a or notifie	12 Was Decedent Ever in U.S. 13 Was Dece	dent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
or items 23	1 Never Married 2 Married Armed Forces? If Yes, spe	cify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
fter de	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 🔀 No specify:	Specify: 13 ack
iours aft	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usu during most of v	al Occupation (Give kind of work done vorking life. DO NOT use retired)	6b. Kind of Business/Industry
36 n 72 h nan "r lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	L. Officer	Security
21215-0036  sold be filed within 72 hour I Mental Hygiene. I marked other than "natu ic event, the Medical Exan To Be Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Mai	iden Surname)
215. be filed mtal Hy rked of ent, th	George Whitlock	Kosetta Scott	White
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death will ment of Health and Mental Hygiene.  Itant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner, must be To Be Completed by Funers	19a. Informant's Hame/Relationship (Type, Print) 19b. Mailing Addre	ess (Street and Number or Rural Route Number	Pro Lynciad 1/6 23231
e, MD 1 and 2 sho Health and Fitem 27 is r traumat	20a. Method of Disposition (20b. Place of Disposition (1	Name of cemetery, Date 2	20c. Location - City or Town, State
Ore, es la of He If ite	crematory or other pla		Charletterellalla
Baltimore, pernit. Pages I an Department of Hea Important: If ite injory or other tr	1 Purple 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 2 Significant of Fungral Service Licenses 22 Name a	nd Address acility	and Service P.A.
Balti permit. Departm Importa injury o	1 as ton C Handan 1201	McCilla st Dalk	). hed. 21217
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.		
mur ciral aminer	Immediate Cause (Final disease a. Hypertensive atheroscle	rotic cardiovascular o	disease Death
anmer	or condition resulting in death)  Due to (or as a consequence of):		
9	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		
red usit	cause. Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence of):		
and transit	events resulting in death) Last Due to (or as a consequence or).		
	X UNPENDED AMENDED 23a, PII, 27, perm, E	g897 11/19/09 TT	
y, P.O. Box 68760, ires that the death certificate be exvisioned by the attending physician to detached for use as the burial.	IF FEMALE: 23c. If yes, outcome of pregnancy	- m	23d. Date of delivery  Month Day Year
certification ce	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (3)		
). Box : the death by the atte	1 Ves 2 No.9 Linknown		pacco use contribute to the cause of death?
P.O. es that the gned by the detach		ying cases given	2 No 3 Probably 4 ✔ Unknown
S, P uires t uires t uires t lid be c	Diabetes mellitus		n 24b. Were autopsy findings available
ord aw req as bee 2 shou		autops perform	med? death?
		26.Place of Death (Check only one)	2 No 1 Yes 2 No
ician: certif rector,	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3		Residence 6 🗸 Other: Scene
of Vi Phys ter this eral di	1 V Yes 2 No 28a Date of Injury 28b. Time of Injury	28c. Injury at Work? 28d. Describe h	now injury occurred
On C anding orb. Tr: Af he fun	1 Natural 5 Pending (Month, Day,Year)	1 Yes 2 No	
/iSic or Atte her des her des hirecto n by th	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	ctory, office building, etc. 28f. Location (S or Town, Si	Street and Number or Rural Route Number, City tate)
Division or spital or Attending spital or Attending tours after death.  Ineral Director: After filled in by the fune of the fu	4 Homicide determined (Specify)		- (-) and manner as stated
		it the time, date and place, and due to the cause in my opinion, death occurred at the time, date	and place, and due to the cause(s)
To the Ho within 24 l To the Flo completely	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	austo	O.C.M.E.	October 20, 2009
	30. Name and address of person who completed cause of death (Item 23a)		
NI	Ana Rubio MD. Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 21201	
State			
Registra	provide provide a serious provides a serious provid		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 perFH G897 11/20/09 TT
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley Wood October 2009 6:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 1145 Steelton Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Months Days September 213-54-2347 **Director** 60 Maryland Usual Residence of Decedent or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If the Azi Is marked they than "natural", or items 23a or 28a-f sho any injury or other tranmatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1145 Steelton Avenue 21224 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Cosmetologist Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Fultz Charlotte Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Wood Husband 1145 Steelton Avenue, Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 Burial 2 XCremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 28, 2009 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Due to (or as a consequence of): Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Hospital Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural injury 5 Pending 2 No Accident Suicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier 12 sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore, MD IN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - State Registrar 34371 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 03:29 PM E. Wortman, Jr. Benjamin OCTOBER 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov. 12, 1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**∑**M 2□ F 55 216-62-7444 Mary Tand Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be nutfiled at Director Yes 2 □ No MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 2425 Washington Blvd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 🛱 Married 1 17 Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 White 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other tha any injury or other traumatic event, the once. Home Improvement Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin E. Wortman, Sr. L., Hoffman Doris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta C. Wortman/Wife 7829 E. Collingham Dr. Dundalk,MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cedar Hillion Cettler tery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/2009 Brooklyn, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Of Lansdowne talune 2719 Hammonds Ferry Road, Lansdowne, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SHOCK SEPTIC DAYS /Medical Due to (or as a consequence of): Examiner LIVER PAILURE Sequentially list conditions, if any leading I introduced the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner JAMIN 68760, CA FAILURE MONTHS KIDNEY Due to (or as a consequence of): attending physician certificate be Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery that the death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the Ö 9 ☐ Unknown ۵. Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No Division of Vital 1 □ Yes l∐Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier and manner stated. within 2

To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D OCTOBER 20, 2009 D22002 .7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 KAUSETTI, 900 CATON AVENUE, BALTIMORE, MD RADHIKA 31. Date filed (Month-Day, Year) 32. Penistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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NORTMAN

**ORIGINAL** 

Physician /Medical

**Physician** /Medical

Examiner

**Funeral Director** 

Be Completed by Funeral Director

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For State Registrar			•		t of Health a e <i>of Death</i>			Reg. No. 2	חחי	19 3437
Decedent's Name (First, Middle,	,					2	2. Date of Dea Month			3. Time of Death
Dolores L. Wol	lkoff						October	-	200	.   E 1 E - M
. Facility Name (If not institution,	give street and num	nber)		4b. City, T	Town, or Location of	Death		4c. Co	ounty of	Death
Gilchrist Hosp				Tows		4 11			ltim	
Social Security Number 219–22–3936	6. Sex 7 1 ☐ M 2 💢 F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months	1 Year If Under 24 Days Hours	Min	8. Date of Birtl (Month, Day June 17	h v. <sup>Year)</sup> 7 1928	3 14	B. Birthplace (State or Foreign Country) laryland
sual Residence of Decedent	- 52.	81	113.				Jule 11	1320	الاا ت	ar y raild
a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
Maryland Anne A	Arundel	Glen	Burni	.e						1 □ Yes 2 <b>X</b> No
e. Street and Number				10f. Zip (	Code			10g. Citize	n of Wha	at Country?
07 7th Avenue				2	1061			_Uni	ted	States
Marital Status	12. Was Deced	dent Ever in U.S. ces?	13.	Was Decede	ent of Hispanic Origi ify Cuban, Mexican,	in? (Spec	cify Yes or No-	. 14		American Indian, White, etc.
1 Never Married 2 Marrie	ed 1 □Yes If Yes, Give	2 <b>∑</b> No e		1 ☐ Yes 2		v П	/	6	pecify:	White
3 ☑ Widowed 4 ☐ Divorced	Year or Da	ites:							-	
15. Decedent's (Specify only highest			(Give	kind of work	l Occupation k done during most o e retired)	of working	7 I	16b. Kind	ot Busir	ness/Industry
Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	<i>DO NOT use</i> emaker	e retired)			^	ATT TT	'Ome
12 Father's Name (First, Middle, L	ast)		TIONE	aner_		's Name /	(First, Middle,		wn H urname)	-
. Father's Name (First, Middle, L. Howard Webb	,					, , , , ,	,			
Howard Webb  a. Informant's Name/Relationshi	p (Type Print)	1	19h Ma <sup>10</sup>	na Address	(Street and Number		L. Brar Route Numbe		Town St	ate, Zip Code)
onald S. Wolko	, , , ,			_						ryland 21666_
Onato S. Wolkol  a. Method of Disposition	noc	20b. Pla	ice of Dispo	sition (Nam	ne of	e, St				ryland 21666 ity or Town, State
1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	ecify)	cen	netery, crei Trin	matory or otl	her place) uss.Orth.					, Maryland
. Signature of Funeral Service Li	iconcop				1					
. Signature of Funeral Service Li	- 7 . 1				d Address of Facility	Hul	bbard F	Funera	al H	lome, Inc.
M.y.	SI		4	107 W	ilkens Ave	Huk enue,	bbard F , Balti	Tunera imore	al H	ome, Inc. ryland 21229
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Ba. Part 1. Enter the disease, or c shock, or heart failure. List o mediate Cause (Final sease or condition	complications that ca		Do not en	107 Witer the mode	ilkens Ave	Huk enue,	bbard F , Balti	Tunera imore	al H	fome, Inc. cryland 21229
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29c. License number

29d. Date signed (Month, Day, Year)

23

2009

octoner

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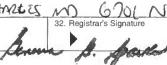
V Og

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

AAMON J CA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death
 Month. 1. Decedent's Name (First, Middle, Last) Year **Physician** WHITE October 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North WEst Kandallstown HOSPITAL BaLTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 **X**M 2 □ F 59 Director 217-54-1784 March 3. Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedley Examination must be mailthed at 1 □Yes 2 V No Director Baltimore Owings Mills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. 31 Enchanted Hills Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No à Specify. **Black** 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fork Lift Operator Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of Drumwright မ Μ. White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Hazella White Wife Enchanted Hills Road Owings Mills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation Inc. 10/23/09 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 s autopsy performed? this certificate 2 1NO 1 ☐ Yes 2 ☑ No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 15HNo 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Box 68760. P.O. I Division of Vital Records.

Baltimore, Maryland 21215-0036

Nothin 24 hours after use....
To the Funeral Director: Aft

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) October, 21, 2009

Abdallah KOFFOUNI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Road, Randallstown, MD 21133 5401 DId

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Jospeh Martin Z		1- For State Contification of Double
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
Medical Exami		Soseph Marchi Zapushek
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  New Cut Road and Upton Road  Glen Burnie  4c. County of Death  Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		214-25-0491 1XM 2FF 20 Yrs. Age (III yis. last bittloay) Months Days Hours Min. 07/22/1989 Foreign Country) Maryland
		Usual Residence of Decedent
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show d at once.	ţ	Maryland Anne Arunder Co. Gien Burnie
e Mar or 28s	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States
with th	rai [	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
death v or item	uneral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
after ral", o	by Fi	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White
hours "natu	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)
136 thin 72 te. than edic.	Completed	12 Sales Associate Retail
5-00 led wit Hygien other	Col	
121! I be fill iental I arked	Be	Frank Martin Zapushek, III Christine Lee Taft
D 2 shoult and M 77 is m	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mr. Frank M. Zapushek, III/Father 600 Nolberry Dr. Glen Burnie, MD 21061
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
nore		1 X Burial 2 Cremation 3 Removal from State crematory or other place)  1 A Departion 5 Other Specific Cedar Hill Cemetery 10/30/2009 Brooklyn, Maryland
altin mit. P partme portai ury oi	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation
		MO1121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  Death  Death  Due to (or as a consequence of):
		Sequentially list conditions,  b:
	je l	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause
· N	Kami	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
executed an and al - transit	dical Examine	d.
D, be e. siciai	(1) (1)	UNPENDED AMENDED
68760 certificate t nding physis	(1) (1)	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Records, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the b	sician/M	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
Box he death c	Physi	1 Yes 2 No 9 Unknown g Unknown
P.O. ss that the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 V No 3 Probably 4 Unknown
JS, F. guires een sig	ted	
SOFC law re has be	Completed	autopsy prior to completion of cause of performed? death?
Division of Vital Records, tall or Attending Physician: The law requir is after death. After this certificate has been silled in by the funeral director, page 2 should be	1 9	1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Be	25. Was case referred to medical 26. Mace of Death (Check only one)  examiner?   Hospital:   Insertions   2   ER/Outpatient   3   DOA   Other;   Nursing Home   5   Residence   6   Other: Scene
of V ig Phy After th	ا: ح	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred
tendin eath. tor: A	Certification:	1 Natural 5 Pending Oct 24, 2009 Pending Investigation Over 24, 2009 Oct 24, 2009 Over 25 No Oct 24, 2009 Over 25 No Oct 24, 2009 Over 25 No Oct 26, 2
or Att or Att after d Direct I in by	Effici	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dj spital hours a meral y fillec		4 Homicide determined (Specify) Major Road / Highway New Cut Road and Upton Road, Glen Burnie , MD
he Ho lin 24   the Fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To t With To I	Medical	and manner stated.  29b Signature and tittle of eestifier // 29c, License number 29d, Date signed (Month, Dav, Year)
		O.C.M.E. October 24, 2009
		30. Name and address of person who completed cause of death (Item 23a)
10		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	
Regist	trar	, 001 g 1 2000 pp. 17"

o Y. Zhao		I- For State	f Marylan		rtment of <i>tificate of i</i>		nd Men	tal Hy		eg. No.	200	9 3	3437
Physicia dical Examir	n/	Registrar  1. Decedent's Name (First, Middle,Last)  Ruo-Yu Zh	ao					2	Date of Deal Month October 1	h Dav	Year	3. Time of 1520	
		4a. Facility Name (if not institution, give 3722 Point of Rocks Road		per)	41	. City, Town, Frederick	or Location of	of Death		4c. Co	ounty of Death derick	1	
Funeral Director		5. Social Security Number 6. Sex 664-01-0454	7. M 2 F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Y	ear If Unde ays Hours		8. Date of Bir October		Foreig		
v any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	n							e City Limits
faryland 28a-f show at once.	Director	Maryland Montgom 10e. Street and Number	ery		Gaith	ersbur 10f. Zip Code			1	0g. Citizen	of What Cou		s 241 NO
with the Maryland ns 23a or 28a-f show be notified at once.	ral Dir	588 Pelican Aven	12. Was Deced		S. 13. Was	Decedent of	877 Hispanic Ori	gin? (Spe	ecify Yes or No		Kong Race - Amer White, etc.	ican Indian,	Black,
ifter death	by Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford  1 Yes  If Yes, Give Year  or Dates:	es? 2 X No	1	s, specify Cub Yes 2 X	No specify	•			ecify: Ch	inese	
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene.  Team 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	leted b	15. Decedent's Education (Specify onl Elementary/Secondary (0-12)				st of working	life. DO NOT	kind of wo	ork done ed)		of Business		
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat r event, the Medical Exa	Completed	17. Father's Name (First, Middle, Last)	4		Comput	er Eng	18.Mothe		(First, Middle,		ware D	evelo <sub>1</sub>	pment_
2121; hould be fill and Mental F is marked rite event, 1	To Be	Cong Zhao 19a. Informant's Name/Relationship (Ty		-	3		reet and Nu		ural Route Nu				
re, MD 2: 3 1 and 2 should f Health and M ff item 27 is m er traumatic		Thomas D. Gorman/S  20a. Method of Disposition  1 Burial 2 X Cremation 3	_	20b. F	13th F Place of Disposi crematory or oth	tion (Name of			ons, 8, Date Der 22,	A Bow 20c. Loc	en Roa cation - City o	d , Ho	ng Kon te
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		4 Donation 5 Other Specify: 21 Signature of Funeral Service License		Mon	itgomery C		Feetli	20	09		hesda, e/Bethe		
Physician	a 34	23a. Part I. Enter the disease, or compl failure. List only one cause on ear		M01	360 Inc.	7557 W	isconsi ng, such as	n Aven	ue, Bethe respiratory ar	esda, M rest, shock	aryland , or heart	Approxi Betwee	mate Interval en Onset and
/Medical :aminer	1 8		Multiple Injur Due to (or as a c		f):								Death
	iner	cause. Enter Underlying Cause	Oue to (or as a c	onsequence o	f):		_						
cuted and large fransit	I Examiner	(Disease or injury that initiated events resulting in death) Last d.	Due to (or as a c	onsequence o	f):								
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Sox 6876( leath certificate e attending phy- for use as the b	/sician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live bir	th nt at time of de	2 Fe	tal death ner (Specify)	3 Ector	oic pregna	ncy	M	ionth	Day	Year
ires that the de signed by the 1 be detached 1	by Phy	Part II. Other significant conditions		death but not r	esulting in the u	nderlying cau	se given în î	Part I.			se contribute t	_	of death? Unknown
cords law requ has been 2 should	Completed									opsy ormed?	24b. Were prior to death?	completion	lings available of cause of No
Vital Rec ysician: The his certificate director, page	o Be C	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	ospital:	patient 2	ER/Outpatient		Other		only one)	Resident	ce 6 🗸 Oth	ner: Scene	
ion of vertiending Ph. eath.	-	27. Manner of Death  1 Natural 5 Pending	28a. Date o	f Injury Day Year) 009	28b. Time of I 1511 hrs	· · · .	Injury at Wo		28d. Describe Driver auto			sion	
Division that or after determined in birecto	Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	28e. Place		nome, farm, street ad / Highway		ice building,	etc.	28f. Location or Town, 3722 Point of				Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	g	29a. Certifier (Check only one) 2 Wedical Examiner	On the basis of	examination a	dge, death occur and/or investiga	red at the tim tion, in my opi	e, date and pric	place, and occurred a	I due to the ca at the time, dat	use(s) and e and plac	manner as si e, and due to	tated. the cause(s	3)
To with	Medi	29b, Signature and title of certifier	And manner sta	aled.			.C.M.E.	er			ate signed (Aber 18, 20		Year)
20		30. Name and address of person who of Margarita Korell MD. As	completed cause sistant Med			enn Stree	t, Baltimo	re, MD	21201				
St	ate	31. Date filed (Month, Day, Year)		gistrar's Signat	le bar	led							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 25, 2009 **Physician** 10:00 Benjamin Anderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George St. Thomas Moore Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1**⊠** M 2□ F Months Days Hours August 20,1926 South Carolina 83 Director 579**-**24**-**8277 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1X Yes 2 □ No DC Washington 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 616 Tuckerman Street, North West 20011 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1845 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, Item College (1-4or 5+) Security Guard Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Capers ည Sarah Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Peabody Street, NW Washington, DC 20011 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronce. Wynnie Anderson-Jones/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Washington National 10/2/2009 Suitland, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Siny ture of Funeral Service Ligenses Wer 7400 Georgia Avenue, NW Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Artenoscieratic Coundiovascular Disease Physician 1 Caus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending physi 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> ENCE PHALOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed Respiratory Failure Ventilator Dependent 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No Chronic Obstructive Lung 0126456 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 30 2009 Name and address of person who comp ted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

14

DHMH 17 Rev 1/2001

32 Registrar's Signature

Due enshury Rd Hyattsuille Mid 207 81

			For State Registrar	State of N	/laryland	d / Depa <i>Cea</i>	artmen rtificat	t of H e of L	lealth a Death	and M		iene2	009	34377
	Physici	an	Decedent's Name (First, Middle,     Maria Genobe)	,	reu						2. Date of Dea Month	Day	Year	3. Time of Death
4	/Media	cal	4a. Facility Name (If not institution,				4h Cihi	Taura or	Location o	f Dooth	Octob	er 9,	2009 nty of Death	2:55 p M
g.	Examir	ier	11814 Pittson		11)		, ,		Sprin				tgome	ry
	Funeral Director	Г	5. Social Security Number 263–15–5664	5. Sex 1 □ M 2 1 7. A	Age (In yrs. la		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Jan. 3	Year) , 1909	9. Birthi	place (State or Foreign ntry) Cuba
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation						1	Od. Inside City Limits
	Maryfi -f sho	to	150	ontgomery			er Sp	rina						1 □Yes 2 <b>X</b> No
	or 28a	Director	10e. Street and Number	on ogomery		~	10f. Zip				[ 1	0g. Citizen o	of What Cour	ntry?
	ath wit 23a c	la	11814 Pittson	Road				0906				USA		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to refined at	by Funeral	11. Marital Status  1 ⚠ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces d 1 Tyes 245 If Yes, Give Year or Dates	s? <b>X</b> No		Was Deced If Yes, spec 1 █ Yes 2		_		ecify Yes or No- Rican, etc.)		Race - Americ Rack, White, cify: W	
Maryland 21215-0036	within 72 ho iene. than "natur re Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-40	r 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	ation luring most )	of workir	ng		Business/In	,
2	filed w Hygiel other th		17. Father's Name (First, Middle, La	get)		Но	nemak	er	19 Motho	r'e Namo	(First, Middle,		wn Ho	me
au	ld be f ental ked o' c eve	To Be	Unknown Abreu	101/						nkno		vaiden Gani	41110)	
Mary	and 2 should beath and Ment n 27 is marked her traumatice		19a. Informant's Name/Relationshi Juan C. Marsan					•			<i>Route Numbe</i> <b>er</b> Spri			,
ē	Pages 1 a nent of He ant: If item ary or othe		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		CE	ace of Dispo emetery, crer	natory or o	ther plac		Oat	ate . 14,		n-City or To indria	
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Li	censee	فلعل		Name an ranci: 00 Un:				Funeral			g, MD 20901
		W 1	23a. Part 1. Enter the disease or c shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line.	. De not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
and the	hysician /Medical		disease or condition resulting in death)	a.Chronic	Obstr		e Lun	g Di	sease				-	20 years
	Examiner			Alzheim			ia							15 years
	cured	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	із и випанци	ence of):								
8760,	ilcate be executed physician and sthe burial-transit	dical Ex	resulting in death) Last	Due to (or a	as a consequ	ence of):								
O. Box 68	attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	n 2 ☐ Fetal tet time of de	death 3[	☐ Ectopic p ☐ Other <i>(sp</i>		/				Date of deliv Month	ery Day Year
Js, P.	signed by the a	र्व	Part II. Other significent condition	s contributing to death	but not resu	Iting in the u	nderlying ca	ause give	en in Part I.					he cause of death?
50.0	w requir	eted									1 U Y			
		Completed				-						med? 2 🖺 No	prior to co death? 1 🗆 Yes	opsy findings available ompletion of cause of
₹	lysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ıtient 2 ☐ E	FR/Outpatier		Othe	)r:		<i>(Check only or</i> ne 5 <b>⊠</b> Resid		Other (Case)	6.)
Division of Vital Records,	uing rin h. After th funeral	Certification: To	27. Manner of Death  1 🔀 Natural 5 🗆 Pending 2 🗀 Accident investiga	28a. Date of Ir (Month, I	njury	28b. Time o Injury		8c. Injury Work	/ at	2	28d. Describe h			197
Divis	s after deat al Director: ad in by the	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e, Place of I	njury - At hor etc. (Specify	me, farm, str	eet, factory	, office		2	28f. Location (S City or Tow		mber or Run	al Route Number,
	within 24 hours after To the Funeral Director Completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying 2 Medical Expenses	Physician: To the best caminer: On the basis and manner:	of examinat	vledge, deat ion and/or in	h occurred vestigation	at the tir , in my o	ne, date an pinion, dea	d place, a	and due to the ded at the time, d	cause(s) and late and plac	manner as a	stated. o the cause(s)
	with com	Σ	29b. Signature and title of certifier			1 4 4		10.	number			_	ned (Month,	,
7				ricun	-	10	-	)-/	940	0		10-	13-2	009
	J.		30. Name and address of reson with rnesto Africano,	MD 344	Unive	rsity	Blvd.	. We:	st, S	ilve	r Sprin	g, MD	20901	
H	Sta Registr	-	31. Date filed (Month, Day, Year)	32/Regis	strar's Signat	. pa	Med							

		-	For State of State are Registrar	Maryland / Depa	artment of H tificate of D		lental Hygie	ene 2009	34378
I	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Ruth Mary Elizabeth				2. Date of Death Month October	21, 2009	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give street and number	er)	4b. City, Town, or		October	4c. County of Deat	6:15 PM M
-			Northampton Manor Health  5. Social Security Number   6. Sex   7.		Frederi	.ck If Under 24 Hrs.	8. Date of Birth	Frederic	hplace (State or Foreign
	Funeral Director		5. Social Security Number 215-20-9269  6. Sex 1 □ M 2  7.	Age (In yrs, last birthday) 100 Yrs.	Months Days	Hours Min.	Aug. 27	1909 Ma	ryland
	and show at	ō	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Maryla 28a-f otified	Director	Maryland Frederick	Frederi				0	1 Yes 2 □ No
	with the 23a or	Funeral D	10e. Street and Number 200 East 16th Street		10f. Zip Code 2170	1	100	g. Citizen of What Co U.S.A.	untry?
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decede Armed Force  1  Yes 2  If Yes, Give Year or Date	es?	Was Decedent of His if Yes, specify Cubar 1 ☐ Yes 2 🗐 No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0	2 hours "natur edical ]	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di	ation uring most of worki	ng 16	6b. Kind of Business	Industry
2121	within 7 giene. er than the Me		Elementary/Seconday (0-12) College (1-4	or 5+) life. D	o NOT use retired) omemaker			Own Hom	e
and	oe filed intal Hyg ced oth	To Be	17. Father's Name (First, Middle, Last)  William T. Baer			18. Mother's Name	e (First, Middle, Mai e Mae Un	iden Surname) 1 <b>known</b>	
Mary	12 should be file alth and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print) Mrs. M. Jean Lentz, daug		ng Address (Street a Crabappl	nd Number or Rura	Route Number, C	ity or Town, State, Zig	O Code)
Baltimore, Maryland 21215-0036	Page 1 and lent of Heal nt: If item 2 ry or other	,	20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from S  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	osition (Name of	- 1	Date 20	oc. Location - City or 9 Freder	Town, State
Balti	permit. F Departm Importa any inju		21. Signatur of Funoral Pervice Licensee	M00255 1	Name and Address Seeney and 06 East C	f Basford Church St	PA Funer Freder	al Home	21701
			23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each	used the death. Do not ento line.	er the mode of dying				Approximate Interval Between Onset and Death
	Ph sician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or	as a consequence of):	HOV				
	Examiner	-	Sequentially list conditions, b.	as a consequence of					
X	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	an a scalar control tay					
'n	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or	as a consequence of):					
3760	ificate t ng phys as the I	Medical	IF FEMALE:						
Division of Vital Records, P.O. Box 68760	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	ant at time of death 5	Country Countr	У		23d, Date of de Month	livery Day Year
ds, P.O	quires that the series of signed by all de detail	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	underlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Recor	The law recate has be page 2 sho	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of s 2 ☑ No
/ital	rsician; s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	patient 2  ER/Outpatie	Othe	ace of Death (Chec.		ce 6  Other (Spec	cifv)
n of \	rding Phy ith. ; After this s funeral o		27. Manner of Death 28a. Date of		f 28c. Injury work	/ at	28d. Describe how		
)ivisio	al or Atter s after des I Director d in by the	Certificate:	3 Suicide 6 Could not be 28e. Place o	f Injury - At home, farm, str g, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the besis	of examination and/or inves	stigation, in my opinic	on, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	To th withii To th comp		29b. Signature and title of certifier		29c. License	9 number 05164.		d. Date signed (Mont October 22	
	A		30. Name and address of person who completed cause		Print)	Dr. F	rederin	K, MD	21702
ij	Sta Registr		31. Date filed (Month, Day, Year) 32. Rep	gistrar's Gignatur	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 2009 Physician/ 14, 01:45 AM Gertrude Lucy Beavers Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Solomons Nursing Center Solomons 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral July 5, 1915 Hours Days 1 🗆 M 2 🕱 F Virginia 578-44-3340 94 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Hughesville Charles 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20637 14122 Beverly Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 😾 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **Healthcare** Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) be filed Be 17. Father's Name (First, Middle, Last) n and Mental h ပ Alma Amanda VanLear Edgar Benjamin Quick 1 and 2 should by Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hughesville, MD 20637 Carolyn Hanback / Daughter 14122 Beverly Dr., permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2009 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition 41 Pnysician 419 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to jor as a consequence of: executed and Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the buri P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fib (11/4 Adrial 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 Proc 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi D52242 October 14, 2009 W

Registrar
DHMH 17 Rev 7/2009

State

J. John Barth, MD, 110 Hospital Road, Suite 310, Prince Frederick, MD 20678

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2000

Director

Funeral

2

Completed

Be

ဂ္

Physician/Medical Examiner

Medical Certification: To Be Completed by

29a. Certifier (Check only one)

3 Suicide

4 Homicide

29b. Signature and

**Physician** 

For State Registrar				ryland /		tificat					Reg. N	00	nna	1	31.	381
Decedent's Name (	(First, Middle	e, Last)								2. Date of Month		av	Year	3	3. Time of	Death
Harold	C	hester	Во	oone,	Jr.					Octob			009	5	:20	P. M
Facility Name (If r	not institution	n, give street and	number)			4b. City,	Town, or	Location	of Death		4	c. Count	ty of Deat	th		
St. Mary	y's Ho	spital						dtow					Mar			
Social Security Nur	mber	6. Sex		(In yrs. last b		If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of (Month,	Birth Day, Yea	r)	Co	rthplace (State or Foreign ountry)		
212-64-24		1 🔯 M 2□ I	55 Yrs							08/13	Was	shington,DC				
ual Residence of D	Decedent 10b. County			10c. City, To	wn or Lo	cation	_			_				10d. Inside City Limits		
MD		Marria													1 □Yes	2 💢 No
. Street and Numb		Mary's		AV	enue	10f. Zip	Code				10g. (	Citizen of	f What Co	untry i	?	
	Oakley	Road						20609	)			ŢŢ	.S.A			
Marital Status	JUNIER	12. Was D	ecedent E	ver in U.S.	13.1	Vas Dece	dent of H	lispanic O	riain? (Sp	ecify Yes or	No-	14. Ra	ace - Ame	erican		
Marital Status  1 ☐ Never Married	d 2 🕅 Marr	ied 1 □Ye	Forces? es 2∏7No			If Yes, spe	cify Cuba	an, Mexica	an, Puerto	Rican, etc.)			ack, White	e, etc.		
3 ☐ Widowed 4		If Yes,	Give A			1 □ Yes	X No	Specify	y:			Spec	effy:	wh	ite_	
	15. Deceden	t's Education	ed)	16	a. Dece	dent's Usu kind of wo	al Occup	ation	nst of word	rino	16b.	Kind of	Business/	/Indus	stry	
(Specify) Elementary/Second		st grade complet	e <i>d)</i> je (1-4or 5+	-)	life.	KING OF WO DO NOT U	se retired	d)	VI WUIK					-		
8					e1f	emp1c	yed		-		-#-		owin	g		
. Father's Name (F			_							e (First, Mid						
Harol	d C	hester	Вос	one, S		_			lary		rlot	-		ger		
a. Informant's Nan	ne/Relations	hip (Type, Print)		10												
										ral Route Nu		y or Tow	n, State, .	Zip Co	ode)	
Gerry Bo	oone,				2169	3 0ak	ley	Road	, Av	enue,	MD	2060	9			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

HAROLD Chester

PW 5 State

Registrar

M.D.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ddress of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

itle of certifier

D6088

09 10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rakhi Krishnan, M.D., 26840 Point Lookout Rd., Leonard, MD 20650

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year, 1 4 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay 2009 Month **Physician** October 8, 7:25 A M Alvin Pershing Brode /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Frostburg Nursing & Rehab Center Frostburg Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Days 1 M 2 □ F 218-10-4306 Maryland Director 90 November 26, 1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 □ No Director Midlothian Allegany Maryland 10e. Street and Number 16007 Ritchie Ridge Lane, SW 10g. Citizen of What Country? 10f. Zip Code U.S.A 21543-Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver county government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic ever Rebecca Jane Barnes Howard Brode ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21543-Maryland A. Fay Stanton daughter P. O. Box 389 Midlothian Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Frostburg 4 Donation 5 Other (Specify) Frostburg Memorial Park October 10, 2009 21. Signature of Funeral epvice Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 1. boli-Ursi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years **Physician** ALHEIMERS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown DISONDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed TYPERVIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Hospital or Attending** 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in ! Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completely

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

29c. License number

00 13166

29d. Date signed (Month, Day, Year)

RODUET MIN.

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRACE

08 2009

new

32. Registrar's Signature

			State of Maryland / Department	artment of Health rtificate of Deat			ene 1. No. <b>2 N N</b> (	34382
ı	Physici		1. Decedent's Name (First, Middle, Last)  Allen Walter Burton			. Date of Death	Day 2009	3. Time of Death
0	/Medio		4a. Facility Name (If not institution, give street and number)  Mallard Bay Care Center	4b. City, Town, or Location	ion of Death		4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220–10–6597 12 M 2 F 95 Yrs.		nder 24 Hrs. 8	Date of Birth (Month, Day, ) Jan 19,	rear) (	rthplace (State or Foreign Country) Maryland
6	show	or	Usual Residence of Decedent  10a. State	ocation Cambridge				10d. Inside City Limits
E	with the M la or 28a-f	Funeral Director	10e. Street and Number 520 Glenburn Avenue	10f. Zip Code 21613		100	g. Citizen of What (	127
36	s after death , or items 2:	by Funera	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	Was Decedent of Hispanic If Yes, specify Cuban, Mexi		ify Yes or No- can, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. White
215-00	thin 72 hours ie. an "natural"	Completed b	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during n DO NOT use retired)	most of working	16	 6b. Kind of Busines	
nd 21	oe filed wil tal Hygien d other th	Be Con	7 Me 17. Father's Name (First, Middle, Last)		,	First, Middle, Ma	Automo aiden Surname)	tive
laryla	2 should to and Men is marked raumatic	욘		ng Address (Street and Nu		Route Number,		
more, N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is "Marical Experiment in ust be notified at once.		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition	B Bonnie Brae position (Name of matory or other place) er Mem. Park	Dat	te 20	Oc. Location - City of	
Balti	permit. I Departm Importa any Inju		21. Signature of Funeral Service Licensee	2, Name and Address of Fa Thomas Funera 700 Locust St	acility al Home, treet Ca	, P.A.	e. Marvla	od 21613
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  A Y + e Y i O sc   level h C    Due to (or as a consequence of):  Due to (or as a consequence of):  C					Inièrval Between Onset and Death
9	the death certific y the attending p ched for use as	Physician/Med		□ Ectopic pregnancy □ Other (specify)			23d. Date of o	delivery Day Year
rds, P.	quires that n signed b ild be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Pa	Part I.			to the cause of death?  Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box	an: The law rec tificate has bee or, page 2 shou	e Completed	25. Was case referred to medical	26 F	Place of Death	24a. Was an autopsy perform 1  Yes 2	ed? death	autopsy findings available o completion of cause of ? es 2 No
ion of Vi	nding Physiciath. th. : After this cer e funeral direct	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner Peath 1 Matural 5 Pending investigation investigation	ent 3 DOA Other: 4	Harsing Hom	e 5 Resider	nce 6  □ Other (S w injury occurred	pecify)
Divisi	ital or Atter rs after dea al Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)			City or Town,	State)	Rural Route Number,
	the Hospi nin 24 hour the Funer npletely fill	edical	29a. Certifier  (Check only one)  1 □ Certifying Physician: To the best of my knowledge, deal control one to the basis of examination and/or long and manner stated.	nvestigation, in my opinion,	n, death occurre	d at the time, da	te and place, and c	lue to the cause(s)
	2 1 2 1 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Σ	29b. Signature and title of certified	29c. License numb D 479	12.4	1	Od. Date signed (Mo	06
	5'		30. Name and address of person who completed cause of death (Item 23a) (Type NOMAN TITAN WY 50 3 BY  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Print) RN ST C	AMBR	IDGE	MO	2-1613
	Sta Regist		OCT 13 2009	box				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200 MAE 0 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) DORCHESTER CAMBRIDGE DORCHESTER GENERAL HOSPITAL 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗹 F Days Hours irginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Tyes 2 No Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 420 21613 U 5 A Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 ☑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🖬 No Specify Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD. 21218 Brenda 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Maryland Cemetery 10/13/09 4 ☐ Donation 5 ☐ Other (Specify) Veterans 22. Name and Address of acility
Henry Funeral Home, to
510 washing ton Sti 21. Signature of Funeral Service Licensee MD. 21613 Approximate Interval Between 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical **Examiner** 

the attending physician

Hospital or Attending Physician: The law requires that the death certificate be executed

this certificate

After t

after death Director:

24 hours a

within 2

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita "tedical Exprinterings be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

by

Completed

Be

Examiner Physician/Medical IF FEMALE: \$ Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 26. Place of Death (Check only one)

1 ☐Yes 2 ☐No

25. Was case referred to medical examiner? Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 □Yes 2 □No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1∐Yes 2☑No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

0067465

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abul Foyez Arifuddowla, 219 S. Washington St., Easton, MD M.D. 31. Date filed (Mon

State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 12, Physician Walter Richard 2009 12:42 p M Boehner, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year March 28, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 11 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Year) Days Min. Hours Months 216-58-9709 1951 Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show nd other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1035 Osage Street 20903 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★No 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2本 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Amarried altimore, Maryland 21215-0036 1 ∐Yes 2**X**⊡ No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It was filed within Elementary/Secondary (0-12) College (1-4or 5+) Transporter Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Richard Boehner Marie DeVizia ဂ္ 19a. Informant's Name/Relationship (Type. Print) Nina Paterno/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1035 Osage Street, Silver Spring, MD 20903 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Oct. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) sician and burial-transit death certificate be executed Exam Due to (or as a consequence attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached if P.0. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 🗌 No 3 ☐ Probably 4☐ Unknown 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Division of Vital 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N 1- Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral c 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. Vithin 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie è 0 Oj 30. Nam and add ress of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Registrar's Signal

DHMH 17 Rev 1/2001

Registrar

4

2009

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month

A. park

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MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:09 P M 2009 OCTOBER REBECCA BENSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S BOWIE HEALTH CENTER BOWIE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 3 F 215-02-9777 79 Director DEC. 1929 MARYLAND 6 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 X Yes 2 ☐ No Director PRINCE GEORGE'S MD BOWTE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20715 4000 CLOVER COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: ↑ Never Married 2 Married 3altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☑ No 2 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 SHELTER WORKSHOP PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN NELLIE HOLLAND ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 5411 BERWYN ROAD # 203 BERWYN HEIGHTS, MARYLAND 20743 ANTONIA LEWIS BROWN/REP 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10--14 --2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY 21. Signature of Funeral Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or y one cause on each line. Immediate Cause (Final disease or condition resulting in death) DIABETES MELLITUS **Physician** /Medical Due to (or as a consequence of): **Examiner** RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off The law requires that the death certificate be execute MENTAL RETARDATION and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Tyes 2 4No the detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 2 \ No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D39550 OCTOBER 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE HAJJAR M.D. 4850 FORBES BLVD #D LANHAM, MARYLAND 20706 31. Date filed 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 34387 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 11 2009 12:08 PM M **Physician** Anne Zentgraft Cox /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Calvert. Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 218–30–4434 **Funeral** Months Days Hours Min. Mayor 24 1933 Marsyland 1 ☐ M 2 ☐ F 76 Director Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 10a State ral", or items 23a or 28a-f show Examiner must be notified at Prince Frederick Calvert Maryland 1 □Yes 2K No Director Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code death with 20678 5420 Sixes Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinan once. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3altimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) finance company office manager 18. Mother's Name (First, Middle, Maiden Surname)
Thelma Hutchins 17. Father's Name (First, Middle, Last) Be Albert Zentgraft 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5420 Sixes Road Prince Frederick Maryland 20678 Charles R. Cox husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Central Cemetery October 14 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Barstow Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 SITOURC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** en years disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off burial-transi Due to (or as a consequence of) P.O. Box 68760. ed by the attending physician detached for use as the burial pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of TONKA autopsy performed? Yes 2X No certificate has death? 2 No 1∐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 2 No 1 ☐ Yes Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Attending 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

KN

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

30. Name and address of person

32. Registrar's Signature 132009 pares

who completed cause of death (Item 23a) (Type, Print)

MO

OUSA

29c. License number

29d. Date signed (Month, Day, Year) 10.12.2009

Island Rd .;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 **Physician** Oc. to /Medical c. County of Death 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death Examiner bridge Mallaro orchester Under 24 Hrs/ f Under 1 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛛 F Days Year 220-10-666 Usual Residence of Decedent Marylano Director JaN, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 Pres 2 □ No Director bridge 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 2/61 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No 3 ₩idowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natany Injury or other traumatte event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Seafood ne Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Slac ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lambridge, Maryland 216 13 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Logation - City or Town, State 1 🖫 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/09 Cambridge, 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee Henry Funeral Home, P.A. 510 washington Str Cambridge 10 Washington Str MD. 21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dementz **Physician** avonce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chrane Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s this certificate 1 ☐ Yes 2 HNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ H6 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Box 68760, P.O. I Records, of Vital Division

State

NOMAN 31. Date filed (Month, Day, Year) OCT 1

29b. Signature and title of certifier

2 Accident

4 Homicide

3 Suicide

29a, Certifier

Medical

6 ☐ Could not be

determined

THANKIT 503 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 ☐ Yes 2 ☐ No

1 Dertitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1) 47924

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10.12-09

CAMBRUNGE

29d. Date signed (Month, Day, Year)

MD 216/3

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CRUMBLIN /Medical JAMES EDWARD 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE"S DOCTORS HOSPITAL LANHAM Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Min. 1 ☑ M 2 ☐ F Months Days Hours 579-56-8673 70 Director SEPT 1 1939 SOUTH CAROLINA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show 1 □ X es 2 □ No PRINCE GEORGE'S MD LANHAM Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5302 LANHAM STATION ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHNNIE CRUMBLIN ELOISE YARBOROUGH ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA CRUMBLIN/WIFE 5302 LANHAM STATION ROAD LANHAM, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation - 5 □ Other (Specify) 10-15-2009 SUITLAND, MARYLAND LINCOLN CEMETERY ure of Fune al S- vice L censee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 90 minuses Physician /Medical Due to fr as a consequence of): Examiner OVONAVY Unknown Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Cholesterol 2 🗆 NO 1 □Yes 24\(\overline{2}\)\(\overline{1}\) 1 ☐ Yes Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kood State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 2009 Latricia Rose Dattoli 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 507 Atlantic Ave. Rm. 105 Ocean City Worcester 8. Date of Birth 9/8/1953 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 56 Months Days Hours Min 1 ☐ M 2 ☐ XF 212-60-3775 MD Usual Residence of Decedent 10a, State 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6829 Roberts Ave. 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🏿 No If Yes, Give Year or Dates: Specify Specify: 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clavton Dattoli Rose Danser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Dattoli / daughter 6829 Roberts Ave., Baltimore, MD 21222 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VERAL YES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Examine g physician and as the burial-transit Physician/Medical attending phase as the ed by the a signed I à Completed has s certificate ha lirector, page this certific al director, Be Certification: To hours after death. neral Director: Af y filled in by the fur 24 hours a Medical completely within 2 To the I

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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d other than "natural", or items 23a or 28a-f shorewort, the Medical Experiment must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Mydical Exercitival

Physician

/Medical

Baltimore, Maryland 21215-0036

death with the Maryland

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	•			•	_					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy finding prior to completion death? 1 □ Yes 2 □ No	of cause of
25. Was case refer examiner?	red to medical						26	. Place of Dea	th (C	Check only one)		
12 Yes 2□	No	Hospital	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □	DOA	Other:	4 ☐ Nursing ⊢	lome	5 ☐ Residence 6	Other (Specify)	OTEL
27. Manner of Deatl 1 Natural 2 ☐ Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 □No	280	d. Describe how injury		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At h building, etc. (Speci	ome, farm, stree	t, fact	ory, of	ffice		28f.	. Location (Street and City or Town, State)	d Number or Rural Route I	Vumber,
29a. Certifier (Check only	1 ☐ Certifying Ph 2 ☑ Medical Exar	ysician: niner: Or	To the best of my kno	owledge, death of ation and/or inve	occurr	ed at	the time, my opinio	date and place on, death occu	e, and urred	d due to the cause(s) at the time, date and	and manner as stated. place, and due to the cau	se(s)

E.T 2

State Registrar

31. Date filed (Month, Day, Year) 13 2009 OCT

29b. Signature and title of certifier

WORTH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Division of Vital R To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	To the Hospital or Attending Physician: The law requires that the death certificate be executive after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tre
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		State of Maryland / Depa		Mental Hygi	ene					
	_		tificate of Death		1. No. 2009	34391				
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  WILLIAM JEREMIAH EMERSON		2. Date of Death Month OCTOBER	Day Year 7, 2009	3. Time of Death 6:15P				
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death  QUEEN ANNE S					
Funeral		502 WALNUT STREET  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	CHURCH HILL  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		place (State or Foreign intry)				
Director		218-09-6919 1 <sup>™</sup> M 2 F 93 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, SEPT. 5,		RYLAND				
ryland		10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits				
he Ma	Director	MD QUEEN ANNE'S CHURCH HI		1.0	0:::	1 ☐ Yes 2 🙀 No				
filed within 72 hours after death with the Maryland Hygiene. When than "natural", or items 23a or 28a-f show ent, the Modical Exercitor mast to multipod at	₫	10e. Street and Number 502 WALNUT STREET	10f. Zip Code 21623	10	g. Citizen of What Cou USA	ntry?				
death	Funeral		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer					
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hours tural"	ed by	3 LA. Wildowed 4 □ Divorced Year or Dates: WW II	ent's Usual Occupation	11	6b. Kind of Business/Ir					
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be filk	Be	17. Father's Name (First, Middle, Last)  WILLIAM H. EMERSON		ne (First, Middle, Ma						
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and 2 salth ar 27 is er trau			HORT BRIDGE FARM			10.01				
es 1 a of He of He fitem	Ì	20a. Method of Disposition  20b. Place of Disposic cemetery, crem	sition (Name of atory or other place)		c. Location - City or T					
t. Pag tment tant: I		4 Donation 5 Other (Specify)	S CEMETERY 10-1	2-2009	QUEENSTOWN	, MD				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitor is ust to retified at once.		FE WAR TO THE FE	Name and Address of Facility LLOWS, HELFENBEII 8 S. LIBERTY ST.							
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death				
Physician /Medical	Ì	Immediate Cause (Final disease or condition resulting in death)  a. BRAIN TUMOR								
Examiner		Due to (or as a consequence of):								
P .∺	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
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ath cer ttendir or use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deli	very Day Year				
he dea the a	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		World	Day Teal				
that the phase of	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
equires en sig				1 ☐ Yes	2 <b>≅</b> No 3 ☐ Pro	obably 4 ☐ Unknown				
law re nas be 2 sho	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of				
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endine rath. or: Aft	atio	1 ♠Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	M 1 ☐ Yes 2 ☐ No							
or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town,	eet and Number or Ru State)	ral Route Number,				
spital ours a neral C		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	and due to the ca	use(s) and manner as	stated				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invane)								
Vithi Com	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month					
May	-	J. E. Cercan J. 70.1.	D 23889		10/8/0	7				
. 1		30. Name and address of person who completed cause of death (Item 23a) (Type, F	ret CHENCALINA	Tud 21	620					
Stat	е	30. Name address of person who completed cause of death (Item 23a) (Type, F Tolan & ARPABINE TH, M.S. 223/b56 ST 31. Date filed (Month, Day, Year)  OCT 08 2009  See A. Again	L.	, , , , , ,						
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Physician/cal Examiner Funeral Director	r			e,Last)	_							Reg.				343	
Director	4		THON	Y R	RAY	ELLI	ОТТ				N	Date of Death Month D October 20,	2009	ear	3. Time o 1642	f Death	
Director	Facility Name (if not institution, give street and number)     McCready Hospital							4b. City, Town, or Location of Death Crisfield				h 4c. County of Death Somerset					
		5. Social Security Nui 216-80-12		6. Sex		. Age (In yrs. la	ist birthday) Yr	Month	r 1 Year Days	If Under 24H Hours M	Min.	Date of Birth $2/14/1$		Co	thplace (Si untry) ylanc	• •	
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the Maryland a or 28a-f shu tified at once Director	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	laryland 10e. Street and Numi		Somers	set			10f. Zip	Code	isfie	eTd_	10g	. Citizen of V	What Cou			
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.  teal 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		26356 E  11. Marital Status  1 Never Married		12. V	Was Dece Armed For				nt of Hispa	1817 anic Origin' Mexican, Po		fy Yes or No- an, etc.)		USA ce - Amer nite, etc.	ican Indiar	, Black,	
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Mental Hyg marked off event, the	ا د	Robert .T 19a. Informant's Nam		,	- <del> -</del> Print )		19b. <b>M</b> aili	ng Address		Maxin	ie Mc	:Cready			e, Zip Cod	e)	
permit. Pages I and 2 should Department of Health and M Important: If item 27 is ma injury or other traumatic e	Ĺ	Mandi Ra 20a. Method of Dispo	y Ell	iott (	(Daug	20b.	306 Place of Dispo	sition (Na	ne of cem			glasvi <sub>ate</sub>	lle, F 20c. Locatio			ate	
permit. Pages I an Department of Hee Important: If ite injury or other tr		1 Burial 2 X 4 Donation 5 21. Signature of Fund	Other S	pecify:	emoval from	II State	lisbur		emato	-	_	/2009				yland	
nysician		21. Sapature of Fune all Service Licensee  22. Name and Address of Facility  BRADSHAW & SONS FUNERAL HOME  306 W. Main Street - Cristield, MD 21817  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and															
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physician and he burial - transi	IF FEMALE:  AMENDED 23a, 27, 28a-f, permE, g897 11/24/09 TT  23d. Date of delivered and the second s									of delive	•						
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ires that the d signed by the be detached d by Phy	2	Part II. Other signifi	cant condi				esulting in the	underlyin	g cause gi	ven in Part	l.	23e. Did tot	2 No			e of death?  Unknown	
law requi	חווחובובה											24a. Was a autops perform	y n <u>ed</u> ?		completio	dings availablen of cause of	
ician: The s certificate rector, page Be Cor	ב	25. Was case referre examiner?	_	al Hospita	al: 1	npatient 2	ER/Outpatie	nt 3		of Death (C	Check onl		Residence	6 Oth	er:		
tending Physicath.  for: After this the funeral direction: To	- 15	27. Manner of Death  1 Natural	5 Pen	ding 1	8a. Date of	of Injury Day,Year)	28b. Time o		28c. Injur	y at Work?	28	Bd. Describe h					
Hospital or Attending 124 hours after death. Funeral Director: Afteredy filled in by the funeral Certification:	Accident 3 Suicide 6 X Could not be determined 4 Homicide 4 Homicide 5 Read 10/20/09   Unk   Unk   10/20/09   Unk   Unk   10/20/09   Unk   10/20/09   Unk   10/20/09   Unk   10/20/09   Unk   10/20/09   Unk   10/20/09   Unk   10/20/09   Unk   Un																
To the Hospital within 24 hours To the Funeral completely filled																	
Ž Š		29b. Signature and t	itle of certifi	er	M			29	c. License O.C.N				29d. Date s October			Year)	
		30. Name and addre	MD. A	Assistant I	Medical	Examiner	111 Per	n Stree	t, Baltin	nore, MC	2120	1					
State Registra	~	31. Date filed (Month	n, Day, Year)	2009	37. Re	gistrar's Signat	ure Asar	No.									

		. For	State of Maryland	/ Depart	tment of H	lealth and	Mental Hy	/giene	01.000	
		1 - State Registrar		Certi	ficate of L	Death	1004 (0	Reg. No. LUUY	34393	
Physic		1. Decedent's Name (First, Middle, Las	Fletche	V			2. Date of De Month	Day Year	3. Time of Death	
/Med Exami		4a. Facility Name (If not institution, give			b. City, Town, or	Location of Deal		4c. County of Dea	th	
and the same of th		Salisbury Rehabilt  5. Social Security Member  6. Se	ration + Nursing	Ctr.	Solis Under 1 Year	oury If Under 24 Hrs	O Data of Bi	Wicomi	thplace (State or Foreign	
Funeral Director			M 2□ F 74		Months Days	Hours Min.			auntry)	
and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locat	ion		- / -		10d. Inside City Limits	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Modest Examinating the putified at once.	ctor	MD Dorche	ster (	anh	ridge				1  Yes 2 No	
₹ 8 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?	
as 23a	Funeral	11. Marital Status	Street  12. Was Decedent Ever in U.S.	13 Wa	2/6/ s Decedent of Hi	ispanic Origin? (5	Specify Yes or No	US A 0- 14. Race - Ame	erican Indian	
d 21215-0036 (g killed within 72 hours after death with Hygiene.  The than "natural" or items 23a or ent, the Modical Examinar must be it.		1 ☐ Never Married 2 🗹 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		es, specify Cuba	ispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)	0	e, etc.	
5-0036 72 hours aft natural", or	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		nt's Usual Occupa			Specify: 5/	ack	
215 tthin 72 ne. "na	Completed	(Specify only highest grad		(Give kin	d of work done of NOT use retired	durina most of wo	rking	Tob. Kind of Business.	moustry	
ed with	S	7		Tru	ICK D	river	(E)	Tertiliz	zing Co.	
and antal H sed off	Be C	17. Father's Name (First, Middle, Last)	Fletcher				me (First, Middle 1005 )	e, Maiden Surname)	1/	
Marylahd d 2 should be file th and Mental H; i7 Is marked oth traumatic event	2	19a. Informant's Name/Relationship (T		19b. Mailing A	Address (Street &			ber, City or Town, State,	Zip Code)	
e, Marand 2 Health a Health a cem 27 Is		Louise Mcc	oy daughter	910 F	tighs	treet (	Cambr		land 21613	
MOTO Pages 1 nent of H int: If ite		20a. Method of Disposition 1	Removal from State	. /	on (Name of ory or other place		Date	29c. Lécation - City ér	Town, State	
Baltimore, permit. Pages 1 ar Department of Her Important: If item any Injury or othe puce.	h	4 □ Donation 5 □ Other (Specify,  21. Signature of Funeral Service Licens	<u>uer</u>	22. N	<u>eMeter</u> lame and Addres	s of Facility	Home, 1	Cambridg	e, MD.	
n gg gg		Janelle C.	Henry		NRY FU	Nekal I			MP.21613	
		23a. P rt . Enter the disease, or comp strick, or heart failure. List only o	lications that caused the death. ne cause on each line.	Do not enter t	the mode of dyin	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequer	D-ZCA	les 1	Dura	exe		goon-	
Examiner		Sequentially list conditions	6 Comoray	O+	fere	Dence	nzi		year-	
ted nsit	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	e to (or as a consequence of):						
3 / 60, ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequer	nce of):						
S8/6U icate be e physiciar s the buria	dical		d							
death certificate e attending physic for use as the I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc					23d. Date of de	livery	
b death he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal do 4 ☐ Pregnant at time of dea 9 ☐ Unknown		ctopic pregnancy ther (specify)	у		Month	Day Year	
hat the ed by the detache		9 ☐ Unknown  Part II. Other significant conditions co		na in the unde	rlying cause give	en in Part I	23e Did	tobacco use contribute to	o the cause of death?	
ecords, P.O. law requires that the de as been signed by the 2 should be detached	d by				,			Yes 2 1 Mo 3 P		
eco law rec as bee 2 shou	Completed						24a. Was		utopsy findings available completion of cause of	
VITAI HEC sician: The law certificate has b irector, page 2 si							perfe 1 □ Yes	ormed? death?	s 2 No	
OT VITA Physician: rthis certific ral director, I	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ № 6	Hospital: 1	2/Outpationt	2 □ DOA Othe	ar.	ath (Check only	one) idence 6 □Other (Spe		
On OT VITA reling Physician: th. th. th. the this certification funeral director, p	n: To	27. Manner of Death 1 Matural 5 Pending	7.1	8b. Time of Injury	28c. Injury Work	y at		how injury occurred	спу)	
INISION I or Attending after death. Director: After	icati	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injury. At home	a form atreat	100	Yes 2 □ No	20f Location	(Otto - 1 1 N) 1	David North	
al or A safter il Direction by	Certification: To	4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, iaim, sueet,	, tactory, office		City or To	(Street and Number or R (wn, State)	urai noute Number,	
To the Hospital or Attending P To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		(Check only 2 Medical Exam	slcian: To the best of my knowle iner: On the basis of examination							
o the vithin 2 o the comple	Medical	one)  29b. Signature and title of certifier	and manner stated		29c. License	e number		29d. Date signed (Mons	th, Day, Year)	
F > F 0		1	1/ Lun		02	5741	P	15/1/21	ρ	
<b>*</b>		30. Name and address of person who co		3a) (Type, Prir		01.1		( ( )		
St.	ate	William H. Robi	ns, M.D. 200 32. Registrar's Signature	Civi	4	Salis	oury 11	ND 3180	24	
Regist		31. Date filed (Month, Day, Year)  OCT 0 7 2008	alexan A.	Jack.						

Registrar

		1 - State Registrar	Cer	rtificate of L	Death		eg. No.2 0 0	9	34394	
Physicia	ın	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month October	Day Ve	ar	3. Time of Death 10:40 pM	
/Medica	al	Pinkie S. Franklin  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	oc tobel	4c. County of D	eath	ath	
		Morningside House		Laurel	M 1 - day 0.4 1 (ma		Prince			
Funeral Director		5. Social Security Number 421-62-8334 6. Sex 1 ☐ M 2 1 F 94	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 23	, Year) 915	Countr A1	ce (State or Foreign y) abama	
		Usual Residence of Decedent           10a. State         10b. County         10c. City	, Town or Loc	cation				10d. Inside City Limit		
	ţo	Maryland Prince George's		Laurel				1 □Yes 2X No		
or 28a	Direc	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Country?			
urs after death w urs after seath w van invernier  by Funeral		7700 Cherry Lane, Apt. 202B			707		USA			
	Fune	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	5.   13. V	Was Decedent of H f Yes, specify Cuba	Rican, etc.)	14. Race - A Black, W	Vhite, et	c.		
	þ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	1∐Yes 2∭XNo		Specify:	В.	lack		
natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o	during most of work		16b. Kind of Business/Industry			
than	omo	Elementary/Secondary (0-12) College (1-4or 5+)		<i>DO NOT u</i> se retired <b>nemaker</b>	,	þ	wn Home			
other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surnan						
Menta arked atic e	2	Willie S. Smith	Τ		Pinkie G					
7 Is m traum		19a. Informant's Name/Relationship ( <i>Type. Print</i> ) Renty B. Franklin/Son	19b. Mailin 3013	ng Address (Street a Novak Te	and Number or Rui rrace, Bu	ral Route Numbel urtonsvi	r, City or Town, Sta lle, MD 2	te, <i>Zip</i> ( 2086	e, 210 Code) 0866	
Item 2 Item 2 other		20a. Method of Disposition 20b. P	lace of Dispos	sition (Name of matory or other place			20c. Location - City	y or Tow	rn, State	
rages nent of int: If It		1   1   Rurial   2   At Cremation   3     Removal from State		itan Crem			Alexandri	la,	Virginia	
nporti ny Inji		21. Signature of Funeral Service Licensee	22 H	Name and Addre	ss of Facility Collins	s Funera	1 Home In	ıc.		
] = @ O		23a. Part 1. Enter the disease, pr complications that caused the death							g, MD 2090 Approximate	
hysician and was the burial-transit to be as the burial-transit was as the burial-transit to be a second of the burial-transit to be a second of the burial frame and the burial	Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	•		.9,	,		- 1	Interval Between Onset and Death	
		disease or condition resulting in death)  Due to (or as a consequence)		<u> </u>					years	
		Sequentially list conditions.  Atrial Fibrillation								
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence ot):							
an and ial-tra	Exal	that initiated events c Due to (or as a consequence of the constant of the con	uence of):							
iding physician and ise as the burial-transit	lical	d								
ding p	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregna	incv				23d. Date o	of deliver	~v	
		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Feta	☐ Ectopic pregnanc ☐ Other (specify) _	у	Month Day Year					
by the	Physicia	9 Unknown								
signed by the atter	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Macular Degeneration  1   Yes 2   No 3   I								
peen	Completed									
e has	dmo		sy prio med? dea	<ul> <li>b. Were autopsy findings available prior to completion of cause of death?</li> <li>1 ☐ Yes 2 ☐ No</li> </ul>						
rtificat tor, pa	Be Co	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes th (Check only or	ne)			
this ce al direc	ပ္	examiner? 1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpatient 2 ☐			4 Li Nursing n	ome 5 Resid		(Specify	ed Living Facility	
After	tion:	27. Manner of Death 1 Manual 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	28b. Time of Injury	Wor	ryat k?  Yes 2∐No	28d. Describe h	ow injury occurred			
within 24 hours after death.  Within 24 hours after death.  To the hours after death.  completely filled in by the funeral director, page 2 should be detached for u.  Madical Certification To Be Completed by Physician	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho				28f. Location (S City or Tow	(Street and Number or Rural Route Number,			
al Dir	Cert	4   nomicide building, etc. (Special								
e Funer	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my kno and manner stated.	wledge, deat ation and/or in	th occurred at the tinvestigation, in my o	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mann date and place, and	ner as st d due to	ated. the cause(s)	
Comp	Me	29b. Signature and title of certifier  Maul a Polone	MD	29c. Licens	9923		29d. Date signed (1	Month, L	Day, Year)	
		30. Name and address of person who completed cause of death (Item Marie Dobyns, MD 7350 Van I	n 23a) (Type, Dusen F	Print) Road, #32	0. Laure	1, MD 20	707			
Stat	te				•	•		•		
Registra		31. Date filed (Month, Day, Year)  OCT 1 4 2009  August A	1. 190							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34395 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2009 Morris Eugene Fultz 6:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1705 Country Court Frederick Frederick 7. Age (In yrs. last birthday) If Under 24 Hrs. . Sex 1 🕅 M 2 □ F If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Maryland **Director** 212-38-9191 70 1939 February Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1705 Country Court 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify White Completed 3 Widowed 4 Divorced Specify. other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William R. Fultz Sophia Brice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Country Court, Frederick, Wanda Fultz / Wife <u> Maryland 21702</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State October 0 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2009 Smithsburg, Maryland 22. Name and Address of Facility Keeney and Basford PA Funeral 106 E. Church Street, Frederic 21. Signature of Funeral Service Licenses MO1473 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rest irratory arrest, shock, or heart failure. List only one cause on just line. Approximate Interval Retween Immediate Cause (Final Physician/ disease or condition resulting in death) eavs Medical Due to (or as a consequence of): Exåminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Year Yes signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Priystean; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar an Kouse

Date filed (Month, Day, Year)

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death October 13, 2009 Physician/ 3:20 рм Velma B. George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ivy Manor Chestnut Ellicott City Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 💥 F Days Hours Min 08/13/1930 79 **Director** PA 206-26-5174 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f 1 Yes 2 X No Ellicott City MD Howard 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 United States 3357 N. Chatham Road Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ь Completed by 1 Never Married 2X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: "natural" 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental George Bowser Elmira Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. George - husband 3357 N. Chatham Road Apt. F Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State to Important: If it any injury or o once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Crematory 10/14/2009 4 Donation 5 Other (Specify) Hanover, MD 21. Signature of Furreral Service Ucensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onsetland Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PM en disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal qualified Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Certificate: To Be Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{aligned} \int \) Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: s after death. I Director: After tl

Registrar DHMH 17 Rev 7/2009

State

To the Vithin 2

4 Homicide

29a. Certifier

(Check

only one)

30. Name and address

Medical

determined

INTITIC

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

Registrar's Signatu

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** garrison )avid -009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deal 4b. City. Town, or Location of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Days Min 1 € M 2 ☐ F MD Director 213-70-6021 52 12/29/1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Experience must be notified at 1 ☐ Yes 2 TXNo Director MD Howard Laurel with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ....... rages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 29-ang. United States 20723 8208 Styers Court by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No 3altimore, Maryland 21215-0036 1973-If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No White Specify. 3 Widowed 4 Divorced 1974

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machine Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harriett E. Hanners Robert D. Garrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly C. Roberts - sister 2103 Shuresville Rd. Darlington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ardent Crematory 10/14/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** weeks neum on 1 a disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury executed burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician pe Physician/Medical requires that the death certificate the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.O. I ed by the a 1 ☐Yes 2 ☐ No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 □ Yes 2 No 2 1 ☐Yes To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 ☐ Yes 3√No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) After the funeral 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation neral Director; A 1 ☐ Yes 2 🗆 No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

ofi

the

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29b. Signature and title of certifier

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State Registrar 29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gordon 6, 2009 Samuel Green, Jr. October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8715 Ritchboro Road Forestville Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 8, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min 76 Baltimore, Md. 1933 Director 214-26-1382 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show "natural", or items 23a or 28a-f shov edical Examinar must be putilised at 1 XYes 2 No Director Md. P.G. Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8715 Ritchboro Road 20747 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No 1953— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 □Yes 2 No If Yes, Give Year or Dates: 1955 Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "r any lolury or other traumatic event, the Med once. than, Elementary/Secondary (0-12) College (1-4or 5+) 12th Mechanic Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon ပ Green, Sr. Stanton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Jackson-Green - Wife 8715 Ritchboro Rd., Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Md. Veterans Cemetery 10-15-2009 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityRonald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** balemia /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) dical the

law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, or Attending Physician;

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year		
eart II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably ※☐ Unknown		
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
5. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	e 5X Residence 6 Other (Specify)		
7. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n (Month, Day, Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)		
Pa. Certifier 1 Certifying P  (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, a milner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)		
9b. Signature and title of certifier	29c. License number DOD 5 740	29d. Date signed (Month, Day, Year)		

DHMH 17 Rev 1/2001

State

Registrar

**OCT 1 4 2009** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Margaret Brasher Hervey Month October 21 2009 4:45 AM Medical Facility Name (If not institution, give street and number)
Copper Ridge Care for the Memory Impaired **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 486-24-0722 1 □ M 2 🛛 F Months Days October 6, **Director** 86 Missouri Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant! If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Knoxville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3640 Petersville Road 21758 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Completed by Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Willie Henry Brasher Stella M. Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3640 Petersville Road, Knoxville, Maryland 21758 Douglas Hervey / Son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 23, permit. Page 1
Department of I
Important: If it
any injury or o cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Funeral Servi 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End Stage Dementia Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury use as the burial-tran s been signed by the attending physician and should be detached for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE es, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed' 2 X No 2 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Dir

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) R100599 October 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Bonnie S. Dank CRNP 710 Obrecht Road, Sykesville, Maryland 21784 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2003 Registrar

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28a-f show	rector	10a. State 10b. Cour MD CHZ	ARLES	10c. City, Town or BRAN	DYWINE  10f. Zip Code		100	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
or items 23a or reiner must be	Funeral Director			Ever in U.S. 1	206 3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	U. S. A	ican Indian,
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Impor any Ir once		21. Signature of Funeral Service  23a. Part 1. Enter the disease, other authors follows:	to goto	the death. Do not	22. Name and Address 5635 WASH enter the mode of dyin	HINGTON A	AVE.,LA		
S P	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of): a consequence of):	bacoca	to he	ad		Onset and Death
10 the Funeral Director: After this Sertificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the terms.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of deli Month	ivery Day Year
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FFEMALE:   23b. Was decedent pregnant in the past 12 youths?   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   2	5	be ex cian a	Ē	rooding in dodn't Edoc	Due to	(or as a consec	quence oi):						
FFEMALE:   23b. Was decedent pregnant in the past 12 youths?   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   1   ve birth 2   Fetal death 3   Cother (specify)   23d. Date of delivery Month   Day   Year   2		cate physi the L	dice		d								
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D60417 10/19/09		that the ed by detac			ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	tobacco use contri	bute to th	e cause of death?
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D60417 10/19/09	5 :	ding th. fune	ţi		1	nth, Day, Year)	Injury						
D60417 10/19/09	2	Atter dear octor by the	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Plac	e of Injury - At h	iome, farm, st	reet, factory, office		28f. Location (	Street and Number	er or Rura	l Route Number,
D60417 10/19/09	<u>.</u>	after after	erti	4 Homicide	buil	ding, etc. (Spec	ify)			City or To	wn, State)		
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D60417 10/19/09		n 24 l n 24 l ne Fu oletely	dic				ation and/or in	nvestigation, in my	opinion, death occ	curred at the time,	, date and place, a	ına due to	rie cause(s)
D60417 10/19/09	:	Vithi Vithi To th	M	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed	(Month,	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				1	· M	0		D6	0417		10/10	1/0	7
VERTICAL OF A CONTRACT OF THE FORLOWING MAY 217		9.		30. Name and address of person	-	use of death (Ite	m 23a) (Type,	Print)					
Hemen shay, 63 c I homas jourson Dr. Frederice 195 2110		12	= 1	Hemen shah	165	cTho	mas	Tohnso	n Dr	1 Trec	LENICK	- 1	10 2170

OCT & 7 2009 Server A. Apart ORIGINAL

Registrar DHMH 17 Flev 1/2001

State of Maryland / Department of Health and Mental Hygiene 34402. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 11, 2009 11:00 AM M Phyllis Rae Hetrick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany 171 Ormand Street Frostburg Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director December 19, 1953 Maryland 214-46-3250 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examinar must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 ☐ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 171 Ormand Street 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teller 12 bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bruce W. Hetrick Evva Zinkin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Cutter 21502sister Maryland 12 Glen View Terrace LaVale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland 4 ☐ Donation 5 ☐ Other (Specify) Zion Lutheran Cemetery October 15, 2009 Accident 21. Signature of Funeral Service License 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sudden cardiac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day 5 ☐ Other (specify) signed by the a d be detached f 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 **12** No this certificate 2 No director, 25. Was case referred to medical examiner? released Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After ti 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Sidhu, M.D. 925 Bishop Walsh Rd. Cumberland, MD 21502 Nas State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:15 PM 8 2009 Katherine Hastings Hopkins October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cambridge Dorchester Mallard Bay Center 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F 90 Nov. 1918 156-32-1875 16, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Marylar or items 23a or 28a-f show 1 XiYes 2 □ No must be notified Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) Nurse Public Health n and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter E. Hastings Katie Oliphant ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any Injury or other trau 221 Apple Lane, Preston, MD 21655 Harry R. Hopkins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 DBemoval from State 10/18/2009 | Delmar, Delaware Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Holasclerotic 'Ardiovascular PAPS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Accident ere brovascular 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed No Ronal Tranffience
25. Was case referred to medical certificate To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 1 Vatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Iniury 5 Pending investigation 1 🔲 Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 a 013 pleted cause of death (Item 23a) (Type, Print) ss of person who 30. Name any addr A' NARR PID 21613 100 32. Redistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month of T Year **Physician** Scott Wayne Hebert 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington NMS Healthcare Hagerstown 8. Date of Birth (Month, Day, Year)

July 28,1971 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral X**M 2□ F Months . Days Hours Maryland 38 Director 216-72-6544 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 1 TYes 2 No Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21782 USA iral", or items 23a Examiner must b 16707 Taylors Landing Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XX Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify Specify: <u>م</u> 3 Widowed 4 Divorced "natural" White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juanita Marie Pifer ပ Jimmy Harold Hebert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 16707 Taylors Landing Rd. Sharpsburg, MD 21782 Juanita Reed - Mother t. Pages 1 artment of H ortant: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation oval from State permit. Page Department o Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory Oct.16,2009 Smithsburg, Maryland 21. Signature of Funeral Say Osborne Tunéraly Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque coof) Physician/Medical Examiner Due to (or as a consequence of): attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 2XI No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 8/24/06 UNKM 1 ☐ Yes 3 Accident Vall fren To the Hospital or Attence within 24 hours after death To the Funeral Director: 28f. ocatic (Street d Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Home Tille (Meni/ Co. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0011266 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-0 Hue Hagerstown, MD 21742 580 Northern N. Weeks ✓ strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Clifford Malcolm Hartley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deatl Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 X M 2 □ F June 6,1935 Director 204-28-3819 74 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Exprinimer must be notified at 11☑Yes 2 ☐ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 17737 Red Oak Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 2 1 ☐Yes 21 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Oceanographer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Cross Hartley Ora Whitfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17737 Red Oak Drive Hagerstown, MD 21740 Leticia B.Hartley/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/20/2009 Little Orleans, MD Piney Plains U.M. 21. Signature of Funeral Service Lines 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 10 disease or condition resulting in death) /Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans s a consequence of) Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4☐ Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an cate has page 2 s autopsy certificate 1 ☐Yes 24 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To After this funeral of 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be

Box 68760, P.O. Records, of Vital Division

The law requires that the death certificate be executed or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

within 72 hours after death

Baltimore, Maryland 21215-0036

3 Suicide 4 Homicide

(Check only

29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number

HAGERSTOWN,

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOTANI 31. Date filed (Month, Day,

251 E ANTIETAM ST, 32. Registrar's Sanature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ď℃£ 6,2009 2:27pm M Heise Jr. John Irvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Dec 13, 1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. MaryTand 220-18-2904 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Evar. in a must be nothered at 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6808 Newbold Dr 20817 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No þ Specify Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Law Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Carpenter John Irvin Heise ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Jacqueline M. Heise / Spouse 6808 Newbold Drive Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Falls Church, VA National Crematory 10/08/2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. Ma 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Acute Cerebral Herniation /Medical Due to (or as a consequence of) Examiner Acute Subdural Hematoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Acute head Trama from a fall Exami signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should Chronic Subdural Hematomas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? Yes 2 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 10/05/2009 1 Natural Found down on Floor. 11:00 PM 2XAccident 1 ☐ Yes 2X No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State 6808 Newbold Drive determined 4 Homicide At Home Bethesda, MD 20817

of Vital Records, P.O. Box 68760, Division

JOHN JOHN 380

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Saltimore, Maryland 21215-0036

vithin 24 hours after death.

vithin 24 hours after death.

vothe Funeral Director: After completely filled in by the fune.

State Registrar

Medical

31. Date filed (Month, Day, Year)

and title of certifier

29a. Certifier

(Check only one) 29b. Signatur

Steven D. Lerner MD 1120 19th St. WW Washington, DC 20036 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Frint)

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** German ILKOVICH October 0 10. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Numbe 1 X M 2 □ F Days Months Hours 90 217-21-4816 Director Oct. 20, 1918 Russia Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 X Yes 2 □ No Montgomery Rockville Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 Israel 6111 Montrose Road #622 Funeral and 2 should be filed within 72 hours after death v lealth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: à Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Furniture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Ilkovich Esther (unknown) of Health and Menta ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 10502 Tuckerman Heights Cir., Rockville, MD Benjamin Ilkovitch, Son Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 10/12/09 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance Memorial Park Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si pulure (runaral Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home # 401008 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONI /Medical Due to (or as a consequence of): Examiner ALLURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760. certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐ No the detached 9 ☐ Unknown 9 Unknown ঠ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ DEMENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 □No 1 □Yes 212 No 1 ☐Yes **Physician**: After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of ne Hospital or Attending Pon 24 hours after death.

Permeral Director: After the Funeral Director of the funeral pletely filled in by the funeral 28d. Describe how injury occurred Certification: 5 Pending investigation 28c. Injury at Work? Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

To the Pwithin 24

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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6121

3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOLLAPALI

1 4 2009

DHMH 17 Rev 1/2001

MONTRUSE

29c. License number

D0061096

RUAP

29d. Date signed (Month. Day, Year)

ROCKVILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JENKINS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner DORCHE DORCHESTER GENERAL HOSPITAL AMBRIDGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth **Funeral** 220-28-44 1 □ M 2 □ Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shore event, the Wedical Everying must be notified as 1 PYes 2 No Completed by Funeral Director death with the 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, I'm Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Sewing Fact 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ambridge, MD. 21613 bridge Beltway-Mothy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge 16/09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Henry Fune Ray Home, R.A.
Henry Fune Ray Home, R.A.
SIONASH Ngton St. Cambridge, MD. 2/6/3
Approximate 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY AILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transi EUMONI Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. the 1 TYes 2 No 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 s autopsy 2 No 1 ☐ Yes 2 🗆 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. eral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Abul Foyez Arifuddowla, M.D. 219 South Washington St., Easton, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Joseph Austin JOHNSON Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Ohio 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Yea 1 🔀 M 2 🗆 F Director 212-24-6246 80 Feb. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Washington Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11905 Wesley Drive 21742 USA death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced 4 Divorced Completed white Year or Dates. 1951-53 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma Elementary/Seconday (0-12) College (1-4 or 5+) senior order analyst sandblasting equip 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph A. Johnson Sr. Margaret Lumm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Johnson - wife 11905 Wesley Dr., Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beautiful View Cem. 10/19/09 State Line, Maryland . Signature of Funeral Service License any in 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final McT latic Pnysician, 5 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav 4 Pregnant a 9 Unknown Year Pregnant at time of death ate has been signed by the a page 2 should be detached f 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 은 1 Impatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural (Month, Day, Year) 5 Pending after death. Accident 1 Yes 2 No Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1060396 10/16/09

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARO
31. Date filed (Month, Day, Year)

OCT 16

MURSHED

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and I  State State Certificate of Death	vientai Hygi Re	eg. No. 200	9 34410
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yea	3. Time of Death
1	/Medic		George L. Jackson, Sr.		er 30, 20	09 12:34 A.M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of D	
	Funeral		Washington Adventist Hospital Takoma Park  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom	Birthplace (State or Foreign
	Director		579-53-4538 1 M 2 □ F L4 Yrs. Months Days Hours Min.	(Month, Day, 05/04/1		Country) DC
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla	tor	MD Prince George's Temple Hills			1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What	Country?
	th with	'al D	8601 Temple Hills Rd-, Lot 50 20748		US	A
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a five lical Examination or other traumatic event, it a five lical Examination or other traumatic event.	by F	1 □ Never Married 2 M Married 1 □ Yes 2 M No If Yes, Give 1 □ Yes 2 M No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify:	31ack
Baltimore, Maryland 21215-0036	2 hou latura ical E	ted	15 Decedent's Education 16a. Decedent's Usual Occupation	1	   16b. Kind of Busine	ss/Industry
218	within 7 iene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)			
121	filed wi Hygier other then the		リロス は Truck Driver  17. Father's Name (First, Middle, Last) 18. Mother's Nam	ne (First, Middle, M		ompany/Trans
and	should be filed within nd Mental Hygiene. marked other than matlc event, I'm III	) Be		Burrou		
ary	should and Men and Men marke	2	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru	ral Route Number,	City or Town, State	e, Zip Code)
ž	s 1 and 2 s of Health ar item 27 Is r other trau		Lois J. Jackson/Wife &LOL Temple Hills Rd.	Lot 50,	Temple H	Hills, MD
ore	of He		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City	or Town, State
Ĕ	. Pag tment tant l		4☐Donation 5 ☐Other (Specify) Harmony Memorial ☐☐/☐	4/2009   L	andover-	MD
Bal	permit. Pages 1 Department of the Important If ite any injury or of		21. Signature of Funeral Service Ligense 22. Name and Address of Facility St			
		$\dashv$	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			D 20745 Approximate
	Dhysisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	or respiratory arre	,,,,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (x as a consequence of):			
	Examiner		and stone and diese	Dial	4kis	
	Po tis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1	
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of):			
68760,	tificate be executed g physician and as the burial-transit	al E	but to (or up a consequence or).			
	22 07 65	edical	0.			
Вох	eath certific attending p for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of	*
о Е	the at	Physician/M	in the past 12 months?  1		Month	Day Year
P.0.	that the ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
Division of Vital Records,	w requires that the dispense signed by the should be detached	Completed by	Pt was in Sephe Shock made DNR/DNI by	1	s 2 No 3	Probably 4 💢 Unknown
000	aw rec	olete	family only combat (one and no dialysis as	24a. Was an	24b. Were	autopsy findings available
<u>~</u>	The law ate has bage 2 s	mo:	regrested by lamily	autopsy perform 1  Yes 2	ned?   death	to completion of cause of n? ∕es 2 □ No
/ita	clan: ertifica ctor, p	Bec	25. Was case referred to medical 26. Place of Dea	th (Check only one		
<b>J</b> o	Physic this c	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		nce 6 Other (S	Specify)
on	ding f h. After funer	tion:	27. Manner of Death  10 Natural 5 □ Pending (Month, Day, Year)   28b. Time of Injury Work?  2 □ Accident investigation   1 □ Yes 2 □ No	28d. Describe ho	w injury occurred	
isi	Atten	Certification:	3 Suicide 6 Could not be	28f. Location (Str	reet and Number or	Rural Route Number,
á	s after	Serti	4 ☐ Homicide determined building, etc. (Specify)	City or Town	, State)	
	lospit t hour unera ely fille	edical (	29a. Certifier  (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation.	, and due to the ca	ause(s) and manne	r as stated.
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medi	and manner stated.  29b. Signature and title of certifier  29c. License number		9d. Date signed (Me	
	5. <u>₹ 5</u> 8	-	Aid I Cill Ha	28	OI 1 2 1	and, out, rout
	6	-	30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)		7/30/	07
)			Weishington Advantist Muspital Night Gill MD		, ,	
	Sta	.	31. Date filed (Moduln, Day, Year)  OCT 1 4 2009  Queen 3. Registrar's Signature 3. Saular			
	Registra	ir i	UUI I T CUU LEMAN A. MINOR			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 **Physician** CKSDN NNIE /Medical a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner If Unde Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Min. Hours 1**☑** M 2□ F Months Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Examinational be notified at 1⊈Yes 2⊟No Director 10g. Citizen of What Country? 10e. Street and Number 0748 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1146 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status White, etc 1 □Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sover, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be ၉ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Nu Health an permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation ا Burial العا emoval from State 5 Other (Sp LINCOL 4 Donation 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lun **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy the Hospital or Attending Physician: The certificate 2 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR

State Registrar 32. Registrar's Signatur

31. Date filed (Month, Day, Year)

OCT 1 4 2009

Name and address of pe

32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Sept Year 2252 M 38 200 ence 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) University of Baltimor maryland medictr 9. Birthplace (State or Foreign Country)
DC 8. Date of Birth (Month, Day, Yea 2/2/1954 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Year) 5. Social Security Number 6. Sex Days Hours M 2□F 55 217-64-9444 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 210 No Harwood Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20776 1501 J. Flanders Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status white 1 Never Married 2 Married 1 ☐ Yes 2√XNo Specify. If Yes, Give Year or Dates: 3 ☐ Widowed ★ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Asphalt Driver 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Vista Wise Lawrence E. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harwood, MD 20776 1501 Flanders Lane Laura Annadale Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Mt. Calvary Cemetery 10/3/2009 | Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 2. 12 Ridgely Ave. Annapolis, MD 21401 17 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Syndrome Immediate Cause (Final tout 5 ata disease or condition resulting in death) Due to (or as a consequence of): patic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): 3 Ectopic pregnancy Due to (or as a consequence of): 23d. Date of delivery IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? Year Month Day 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Rib Fractures 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Transplant Tibial Fractures autopsy /performed 1 Yes 2 □ No 1 CL 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day, Year) 27. Manner of Death Injury motorcycle Accident Sept 19, 2009 2010 pm 1 | Natural 5 Pending 1 ☐Yes 2 🗹 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**Physician** /Medical Examiner Examine law requires that the death certificate be executed

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene. and the Health and Mental Hyglene antif Item 27 is marked other than "natural", or Items 23a or 28a-f show antif Item 27 is marked other than "Modical Evanther must be notified at any or other traumatic event, it is Modical Evanther must be notified at

Baltimore, Maryland 21215-0036

led by the attending physician and detached for use as the burial-tran signed by to director, page 2 should peen has certificate this

After this within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

Physician: The

Hospital or Attending

Physician/Medical 3 Completed Be Certification: To

3 ☐ Suicide 4 ☐ Homicide

(Check only one)

29a. Certifie

State

2

Medical

29b. Signature and title of certifie

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated. 29d. Date signed (Month, Day, Year)

Ocean City, MD

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene Street Baltimore, 22 South Wend

32. Registrar's Signature 31. Date filed (Month, Day, 06 2009 OCT

6 Could not be determined

Registrar

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 34413 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 3:35 PM KENNELL CHARLES 2009 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ALLEGAN GREEN WOOD ST ELLERSLIE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 M M 2 □ F Months 214-32-3133 Yrs 6-20-1935 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State FLLERSLIE 1 XYes 2 No ALLEGANY MA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29 5 21 USA 10206 GREENWOOD ST Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CAR DEALERSHIP LABORER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KENNELL LOWERY CLINTON InelmA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $z_{i529}$ 19a. Informant's Name/Relationship (Type. Print) /wife 10206 GREENWOOD STPOBOX 244 Ellerslie Lulu Belle Kennell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ■ Removal from State HYNDMAN, PA Comps 10-7-09 CEM 4 Donation 5 Dother (Specify) 169 CLARENCE ST 21. Signature of Funeral Service Licen 22. Name and Address of Facility HUNDMAN PA 15545 HARVEY 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). d. Date of delivery Year Month Day e contribute to the cause of death? 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

alth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me

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Department of Health Important: If item 27 any injury or other trong once.

Baltimore, Maryland 21215-0036

be detached for use as the burial-transit	
	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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	Certification: To Be Completed by Physician/Medical Examine
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Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown	al death 3 🗆 Ectopio			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 ☑ Yes 2	use contribute to the cause of death
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings avair prior to completion of cause death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 I Nursing F	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, t)		
	nysician: To the best of my kno niner: On the basis of examina				and manner as stated. d place, and due to the cause(s)

5 nde State Registrar 29b. Signature and title of certifier

29c. License number D0023371 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21502 902 SETON DR SUITE 102 CUMBERLAND MA ZAMAN MO QAMAR

32. Registrar's Signature

09-07802 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mark Kodey State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 7, 2009 1926 hrs Medical Examiner MARK KODEY 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Director 150-52-3734 **52** FEB. 26, 1957 NEWTY JERSEY 1 X M 2 F Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County items 23a or 28a-f show ast be notified at once. Yes 2 X No MARYLAND **QUEEN ANNE'S** CHESTER permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1332 CALVERT ROAD 21619 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. or other traumatic event, the Medical Examiner must be Funer Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Yes 2 X No Yes 2 X No specify: Specify: WHITE 4 X Divorced f Yes, Give Year Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 3 SENIOR FIELD ENGINEER GOVERNMENT SERVICES 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be JUNE ANN KRAUSS CYRIL F. KODEY, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7250 MANDAN ROAD, GREENBELT, MD 20770 MARYANNE DRENGA/SISTER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, OCT. 9 Burial 2 X Cremation 3 Removal from State CHESAPEARE PEREMATION STEVENSVILLE, MD 2009 Donation 5 Other Specify CENTER 21. Signature of Funeral Service Licer FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 980 **20** 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Drowning Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? ✔ Yes 2 No 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Other<sub>4</sub> examiner? Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 After this 1 Yes 2 No 28a. Date of Injury Oct 7, 2009 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject's sailboar capsized 1737 hrs Natural Director: 5 Pending Yes 2 V No within 24 hours after death 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Bay Waters off Kent Island Beach 2, Chester, MD To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 8, 2009 O.C.M.E. Name and address of person whe completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner egistrar's Signatu State Registrar

			For State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of I			iene <sub>eg. No.</sub> 2000	31.1.15
			1. Decedent's Name (First, Middle, Last)				Date of Deat     Month		3. Time of Death
	Physicia /Medic		Babette Lapides Koch				October	8, 2009	11:05 P.M
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Deat	
r qr	F		Montgomery Hospice Casey Ho 5. Social Security Number   6. Sex   7. Ag	use e (In yrs. last birthday)	Rockvill If Under 1 Year		8. Date of Birth (Month, Day,		hplace (State or Foreign untry)
	Funeral Director		049-24-9673 1□M 2X)F	76 Yrs.	Months Days	Hours Min.	(Month, Day, May 1,	1933 Coni	necticut
	P		Usual Residence of Decedent	10c. City, Town or Lo	antinu				10d. Inside City Limits
	shov	'n	10a. State 10b. County						1 □Yes 2 No
	the M	Directo	Maryland   Montgomery  10e. Street and Number	Silver Sp	10f. Zip Code		1	0g. Citizen of What Co	untry?
1	aa or		3330 North Leisure World Bl	vd., #501	20906			United Sta	tes
	death	Funeral	11. Marital Status 12. Was Decedent Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Exantinar must be matthed at		1 Never Married 2 X Married 1 Yes 2 X If Yes Give	Jo	1 □Yes 2 🗚No	Specify:	Thousan, every	Cassifu	
Ö	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced Ye ar or Dates:  15. Decedent's Education	16a Dece	dent's Usual Occup	pation		16b. Kind of Business/	ucasian
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212	d with	E	Elementary/Secondary (0-12) College (1-4or 5	Nurs	e			Medical	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surname)	
<u>ya</u>	ould Men narke	ရ	Louis Lapides	405-14-75	A 11 (01	Mildred S		r, City or Town, State, 2	7:- ()
<u>⊠</u>	d 2 sh th an t7 Is r traur		19a. Informant's Name/Relationship (Type. Print)  Elizabeth Koch, Daughter	l l				ington, DC	
ē,	s 1 an f Hea Item 3		20a. Method of Disposition	20b. Place of Dispo		1 1	Date	20c. Location - City or	
altimore, Maryland 21215-0036	Page: nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ♣ Removal from State 4 ♣ Donation 5 ☐ Other (Specify)	Lifelegac		, 001.		Tucson, AZ	
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the notified at once.		21. Signature of Funeral Service Licensee  Burne M The	Ť	2. Name and Addre	ss of Facility Mortuary	Service		20910
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not ent					Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition METASTA	TIC UTERIN	E CARCING	OSARCOMA			Onset and Death
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	Examiner	_	Sequentially list conditions, b.	was and the same of the					
2	ted sit	nine	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	a consequence of):					
7	execunand and al-trai	Examiner	that initiated events c.	a consequence of):					
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89	ertifica ing ph	Medi	IF FEMALE:						
Вох	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
о О	at the de by the a tached f	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	t time of death 5 L	Other (specify) _				
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m m	The la	Juo (					autops perfor	med?   death?	completion of cause of
/ita	ysiclan: The lis certificate hidirector, page	Be (	25. Was case referred to medical examiner?		Tou	26. Place of Deat			
<b>J</b>	Physi this o al dire	0		ent 2 ER/Outpatie	nt 3 🗆 DOA		_	ence 6 MOther (Spe	ecify)HOSPICE
nc	ding Phys h. After this funeral di	tion:	27. Manner of Death  1  Natural 5  Pending (Month, Da  2  Accident investigation		Wor	ryal 'k? ]Yes 2□No	280. Describe n	ow injury occurred	
Division of Vital Records,	Atten r deat ector: by the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj	ury - At home, farm, str				treet and Number or R	ural Route Number,
á	al or safter	Certification: T	4 ☐ Homicide determined building, ef	c. (Specity)			City or Tow	n, State)	
	To the Hospital or Attending Physiclan: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical (	29a. Certifier (Check only one)  XXCertifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in					
	To the vithin To the compl	Me	29b. Signature and title of certifier	201	29c. Licens		2	29d. Date signed (Mon	th, Day, Year)
	5		J. Kouatchou	1 1110	163	3748		OCTOBER 9,	2009
	_		30. Name and address of person who completed cause of c						
			JOCELYNE KOUATCHOU, M.D., (31. Date filed (Month, Day, Year)	1 0'		ROAD, RO	CKVILLE,	, мы 20855	
	Sta Registr		OCT 14 2009 Centur	ars Signature	Mil.				

DHMH 17 Rev 1/2001

			1 - State State Registrar	of Maryland /	Department of I		tal Hygiene Reg. No.	2009	34416		
	Physici		1. Decedent's Name (First, Middle, Last)  Louis Lee	I	Lawrence		Date of Death Month Day	Voor	J 10 J M		
The state of the s	/Medic Examir		4a. Facility Name (If not institution, give street and WMIFS - Braddac			r Location of Death		County of Death  17/129an			
	Funeral Director		5. Social Security Number 218–42–2130 6. Sex 1 🖁 M 2 🗆 I	7. Age (In yrs. last b	oirthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. E Hours Min. 0	Date of Birth Month, Day, Year) 1/19/1947	9. Birthplace Country) Maryla	(State or Foreign and		
	aryland show	_	10a. State 10b. County	10c. City, To	wn or Location	,			Inside City Limits		
	with the Ma 3a or 28a-f	Funeral Director	WV Mineral  10e. Street and Number  206 Silver Tree Apt	S •	Ft. Ashby  10f. Zip Code  26	719	10g. Citiz	zen of What Country? USA	1 □Yes 2X No		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be rediffed at	by Funera	1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. Forces? s 2 XNo Give r Dates:	13. Was Decedent of H If Yes, specity Cub 1 □ Yes 2 ▼ No	dispanic Origin? (Specify an, Mexican, Puerto Rican Specify:	n, etc.)	4. Race - American I Black, White, etc. Specify: Whi	,		
21215-0036	1 and 2 should be filed within 72 hours after deat Health and Mental Hygiene. em 27 is marked other than "natural", or items :	Completed	15. Decedent's Education (Specify only highest grade complete	16	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Carpenter	during most of working d)		d of Business/Indust	try		
land 2	ld be filed v lental Hygid ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Last) Stanley	Lawrence	1	18. Mother's Name (Fin			<u> </u>		
, Mary	and 2 shou salth and M n 27 is mar er traumat		19a. Informant's Name/Relationship (Type. Print) Judy R. Lawrence / Wi	1	9b. Mailing Address <i>(Street</i> 206 Silver Tr				,		
Baltimore, Maryland	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other other.	1.5	20a. Method of Disposition 1 ☐ Burial 2 【3 Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place cemel	of Disposition (Name of tery, crematory or other place erland Cremat	ory 10/12/2	009 Cum	cation - City or Town,	MD		
Ball	Departiment Important In State		21. Sign ture of Funeral Service Cicensee		404 Decat	ss of Facility Adams ur Street,	Cumberlan	nd, MD 21	502		
	Physician /Medical Examiner			to (or es a consequence	CANCE	1.00	spiratory arrest,	Int On	pproximate erval Between iset and Death		
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  c	to (or as a consequence							
.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	outcome of pregnancy ve birth 2 Tetal dea egnant at time of death iknown		у	2	3d. Date of delivery Month Day	y Year		
rds, P.	w requires that s been signed t should be deta	by	Part II. Other significant conditions contributing to	death but not resulting	in the underlying cause giv	en in Part I.		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Monkno			
al Records,	: The law re cate has be page 2 sho	Completed					24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy prior to comple death? 1 □Yes 2 E	etion of cause of		
Vital	<b>hysician:</b> The la his certificate ha I director, page 2	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	☑Inpatient 2☐ER/0	Outpatient 3 DOA Oth	26. Place of Death (Cher: 4 ☐ Nursing Home		Other (Specify)			
$\subseteq$	ng the	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (N 2 ☐ Accident investigation		Time of 28c. Injury Wor		Describe how injury				
Division	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla	ice of Injury - At home, ilding, etc. (Specify)	farm, street, factory, office	28f. L	ocation (Street and City or Town, State)	l Number or Rural Ro	oute Number,		
	he Hospi n 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To 2 ☐ Medical Examiner: On the and m	the best of my knowled e basis of examination a anner stated.	ge, death occurred at the ti and/or investigation, in my o	me, date and place, and opinion, death occurred a	due to the cause(s) t the time, date and	and manner as state place, and due to the	ed. e cause(s)		
	Tor With	Σ	29b. Signature and title of certifier	2//	29c. Licens	e number	29d. Date	e signed (Month, Day	( Year)		
	MLS	}	30. Name and address of person who completed c. Shiv C. Khanna, M.		a) (Type, Print) National Hig	ghway, LaVal	e, MD 21	1502			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 13 2009	. Registrar's Signature	parked						

DHMH 17 Rev 1/2001

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Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

State Registrar 902 Seton Dr., Cumberland, MD

MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arrisueno,

Juan A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** October 2009 3, Eleanor Ann Murray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 K F Months Days Hours 80 1929 Pennsylvania Director 089-22-3804 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f sh 1 Yes 2 No Director Marvland | Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 4112 Bye Forde Court 20895 United States Funeral death 1 s 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items: other traumatic event, the Medical Examination. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: White 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Secretary</u> Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marling Jay Ankeny Eleanor Kulp ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Andrew Murray / Olney Laytonsville Rd., Olney, MD 20832 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages 1
Department of H
Important; If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Middleham Chapel 10/12/2009 Lusby, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 BRause 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Atrial Fibrillation burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Vear 5 Other (specify) ed by the a 9 Hinknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform certificate 2 No 2 🗆 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours at Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Kshama Garg, MD, 1500 Forest Glen Rd., Silver Spring, MD 20910-1484

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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October 5, 2009

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ack

32. Registrar's Signature

Silver Spring, MD 20902

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 26,2009 6:40 a M Van Nguyen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 ☑ M 2 □ I 89 Yrs. Director May 20, 1920 Vietnam 219-96-5426 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sh the Wedical Evaminer must be notified 1 ☑ Yes 2 ☐ No Director Germantown Maryland Montgomery with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States 19135 Cherry Bend Drive r death by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than 9 Businessman Paint Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nt of Health and Ment t: If item 27 is marked or other traumatic e ဥ Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19135 Cherry Bend Drive; Germantown, MD 20874 <u> Giang Nguyen / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 10/5/2009 Brentwood, MD 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Er, er the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Obyse (Final) Physician umoni disease or condition resulting in death) /Medical Due to 1 r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit be executed Due to (or as a consequence of): Box 68760, Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the templates. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1:02 AM **Physician** 2009 )C 1001 HONER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 □ M 2 □X 73 14 1936 NIGERIA Sept. Director 217-83-5677 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h Counts 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director ANNE ARUNDEL ODENTON MD 10f. Zip-Code 10g Citizen of What Country? 10e. Street and Number ō or items 23a 21113 NIGERIA 110 HIDDEN HILL CIRCLE Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No BLACK Specify: à 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOVITA IBEH JOSEPH IBEH မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and is mg 110 HIDDEN HILL CIRCLE ODENTON, MARYLAND 21113 Department of Health Important: If item 27 ONWUEGBULE/DGT PHILOMENA 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State or o injury c 4 Donation 5 Other (Specify) 10-30-2009 | IMOSTATE, NIGERIA FAMILY PLOT 22. Name and Address of Facility Licensee J. B. JENKINS FUNERAL HOME 21. Signature of Euneral Service any 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SULMONG disease or condition resulting in death) /Medical Due (or as a consequence of): **Examiner** anaplastic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as i IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Tectopic pregnancy Month Day in the past 12 months? 5 Other (specify) signed by the att 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 Probably 4 Unknown 2 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21 No 1 ☐ Yes 2 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Depatient 2 3 🗌 DOA 1 🗌 Yes 2 ER/Outpatient မ 27. Manner of De th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No Director: Af Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral I the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 (1) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2 Registrar

31. Date filed (Month, Day, Year) OCT 1 4 2009

29b. Signature and title of certifier

IESSEN 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St. Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 9, 8:00 p<sup>M</sup> Harvey Jackson Poole, Jr. 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Maryland Months Days June 3, 1927 1 🕅 M 2 🗆 F Hours Director 216-16-0458 82 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Directo 1 Yes 2 X No Maryland Solomons Calvert 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 510 Aldersgate Court 20688 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: "natural" 3 Widowed 4 Divorced Year or Dates. 1942-46 white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Adjuster Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Harvey Jackson Poole, Sr. Ethel Comlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important, If item 27 is any injury or other trau Mildred Elizabeth Poole / wife 510 Aldersgate Court, Solomons, MD 20688 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/10/09 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. . Signature of Funeral Service License P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) GLIOBLASTOMA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CORONARY ARTERT DUFTSF Completed 1 Yes 2 -No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETTI MELLITU autonsy 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 3 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Aursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical

Records, Division of Vital Hospital or Attending

JRW 15+1

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John H. Weigel, MD, 110 Hospital Road, Suite 310, Prince Frederick, MD 20678

👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D26358

29c. License number

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

(Check

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07683 State of Maryland / Department of Health and Mental Hygiene Mark Pritchett Certificate of Death 1- For State Rea. No 10/9/09 Amended #28F Registrar 2. Date of Death 1. Decedent's Na Physician/ Month Day October 3, 2009 0530 hrs Mark Wayne Pritchett, Sr. **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Peninsula Regional Medical Center g. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Country) Maryland **Funeral** Hours Months Days 06/22/1955 Director 54 212-66-1190 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State iny 1 Yes 2 X No Hurlock 23a or 28a-f show notified at once. Maryland Dorchester the Maryland irector 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21643 4289 Osborne Road ō 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, hours after death with 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White etc. or items Armed Forces 1 Never Married 2 X Married 2 X No Yes White Specify. Yes 2X No specify: f Yes. Give Year Divorced 3 Widowed 4 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 I
nent of Health and Mental Hygiene. it: If item 27 is marked other than "other traumatic event, he Medical Construction Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Wilkerson Merritt Roosevelt Pritchett æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4289 Osborne Road, Hurlock, Maryland 21643 Melissa Sue Pritchett/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition ltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/7/2009 Hurlock, Maryland Unity Washington Cem. ment c tant: or otl Donation 5 Other Specify 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 21. Sunature of Funeral 106 Main Street, East New Market, Maryland21631 Approximate Interval Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on Death /medical Multiple Injuries Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and executed Physician/Medical AMENDED UNPENDED e attending physician for use as the burial requires that the death certificate be 23d Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE Year Day Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Linknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ğ Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy death? performed? has 2 No page 2 ✓ Yes 2 1 🗸 Yes this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Be Other<sub>4</sub> Nursing Home 5 Residence 6 examiner? Hospital: 1 / Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year Oct 2, 2009 28b. Time of Injury After 27 Manner of Death Struck by tractor or bush hog Certification: 1700 hrs 1 ✓ Yes 2 No 1 Natural 5 Pending To the Funeral Director: completely filled in by the Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 4438 Hurlock EM Rd 1289 Osbourne Road, Hurlock, MbHurlock, MD Could not be 3 Suicide determined (Specify) Field Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifie 29b October 4, 2009 O.C.M.E.

DHMH.17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signatur

Margarita Korell MD.

31. Date filed (Month, Day, Year, OCT 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Keith Jones Patterson /Medical Jown, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** 1COMICC If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1**⋈**M 2□ F Months Min Director 214-68-5122 52 1957 June 6, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Dorchester Cambridge Director tyr Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a 518 Glenburn Ave., Apt. 302 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Howard Patterson Anna Lee Jones ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Is n other traun Leigh Ann Williams daughter 2 Boston Drive, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem'. 10/15/09 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASTRIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Exam and as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Pother (Specify) Hosfic R 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician the signed by certificate has been filled in by the funeral director, this after death 24 hours a completely within 2 To the I

Baltimore, Maryland 2121

State

Registrar

Medical

29a. Certifier

(Check only one)

32. Registrar's Signature

00

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Humm

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d, Date signed (Month, Day, Year)

SACis Buy up 2/802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9, 2009 Year **Physician** 3:50  $P^M$ Jon Martin Peckenpaugh /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Greenbelt 6809 Springshire Way If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1 M 2 □ F 480-62-3407 Feb 24, Iowa 61 1948 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Experiment and the notified at 1 Yes 2 No Director Prince George's Greenbelt MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20770 6809 Springshire Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 should be filed with and Mental Hygier 7 Is marked other the Hydrogeologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Gertrude Pridgeon Clarence Milburn Peckenpaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun once. 6809 Springshire Way Greenbelt, MD 20770 Cheryl J. Peckenpaugh/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Final Journey Crematory 10/13/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic pancreatic cancer Immediate Cause (Final 3/2000 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 □ No Day 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à ] No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 📉 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manper of Death Natural 2 Accident To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

completely filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ∉ertifier 1650 Orkans St Roun 689 Balkmar, MD 21231

15

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2009

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			1 - State Registrar	iryland /	•	tificate of	Death		eg. No.	2009		426
4	Physici	an	1. Decedent's Name (First, Middle, Last)					Month October		200 <sup>Year</sup>	3. Time of E	PM
	/Medic		Roland Bowen Rawlings  4a. Facility Name (If not institution, give street and number)		·	4b. City, Town, or	r Location of Death	OCCOBCI		inty of Death	13.40	
1	Examin	er	Calvert Memorial Hospital				rederick			Calver	t	
	Funeral	- 7	5. Social Security Number 6. Sex 7. Age	(In yrs. last		If Under 1 Year Months Days		8. Date of Birth (Month, Day	, Year)	9. Birthp	lace (State or	Foreign
	Director		219-16-1294		Yrs.			May 1,	1922	Mar	yland	
	land ow tt		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation				1	0d. Inside City	y Limits
	Mary I-f sh fied a	tor	Maryland Calvert	Princ	e Fr	ederick					1 ☐ Yes	2 X No
	or 28a	irec	10e. Street and Number			10f. Zip Code			_	of What Cour	•	
	23a c ust b	ral	610 Hallowing Point Road			20678				d State		
	tems tems	nue	11. Marital Status 12. Was Decedent E Armed Forces?		13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	rs after I", or i	by F	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ N if Yes, Give 1 ☐ Wildowed 4 ☑ Divorced Year or Dates: 1	945–46		I□Yes 2∏No	Specify:		Spe	ec <i>ify:</i> Whi	te	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)		6a. Deced	lent's Usual Occup	ation	ina	16b. Kind o	of Business/Inc	dustry	
218	within 7 ene. than "r be Med	nple	Elementary/Secondary (0-12) College (1-4or 5	+)			during most of work					
121	filed w Hygier ther thent, the	Co	8 17 Febbore Name (First Middle Leet)	1	ndepei	ndent Newsp	aper Distri 18. Mother's Name		Newsp			
and	ould be fi Mental H arked otl	Be	17. Father's Name (First, Middle, Last)				Grace V		waiden Sui	namej		
Maryland	should nd Me mark matic	2	Joseph Rawlings  19a. Informant's Name/Relationship (Type. Print)	1	19b. Mailir	g Address (Street	and Number or Run		r, City or To	wn, State, Zip	Code)	
	nd 2 saith ar 27 is r trau		Clarke Rawlings / Son		610	Hallowing	g Point Ro	d Prin	ce Fr	ederic	k. MD 2	20678
J.	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			sition (Name of natory or other place		Date		on - City or To		
Ë	Pages ment of h ant: If ite ury or of		1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1		Cemetery	1	0/2009	Barst	ow, Ma	ryland	
Baltimore,	permit. Pages 1 and 2. Department of Health at Important: If item 27 is any Injury or other trauone.		21. Signature of Funeral Service Licenseev	7			ss of Facility Rau Island Roa					5
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on ach line.	the death. [							Approximate Interval Betw	_
	Physician		Immediate Cause (Final disease or condition	imediate Cause (Final sease or condition 45 to the 30 m.s.)								
4	/Medical Examiner		resulting in death)  Due to (or as	a consequen	ice of):	-	,					
	LAdillilei	<u>.</u>	Sequentially list conditions, b. Due to or as	a conse lien	rce ofi:							
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	a conse <sub>q</sub> acri	oc ou							
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	certifica nding ph ise as th		IF FEMALE: WA								A	
Вох	leath certif attending I for use as	Physician/M	23b. Was decedent pregnant	2 Fetal de	ath 3	Ectopic pregnanc	y		23d.	Date of delive Month		ear
P.0.	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of deati	n 5L	Other (specify) _						
	ires that the de signed by the a 1 be detached 1	y Ph	Part II. Other significant conditions contributing to death be	at not resultin	ng in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use	contribute to t	he cause of de	eath?
rds	requires sen sign	ed by	Have terior					1 □ Y	'es 2□N	lo 3 ☐ Proi	bably 4 🗆	nknown
O O	w ds	Completed	11					24a. Was a	an 2	4b. Were auto	ppsy findings a mpletion of ca	available
Ä	The lav ate has page 2 s	mo						perfoi	med? 2 ☑ No	death?		1030 01
/ita	cian: ertific ector,	Be (	25. Was case referred to medical exampler?		/	l au	26. Place of Deat	h (Check only o	ne)			
or	Physician: The la this certificate har ral director, page 2	은	1 Yes 2 No Hospital: 1 Inpatie		/Outpatier Bb. Time o		4   Nursing Ho	ome 5 Resid			fy)	
Division or Vital Records,	ne fter	Certification:	1 ☑Natural 5 ☐ Pending (Month, Day		Injury	Wor	ryat rk?  Yes 2∐No	28d. Describe h	ow injury oc	curred		
/isi	Attending r death. ector: After by the funer	fical	3 Suicide 6 Could not be 28e. Place of inju	ury - At home	e, farm, str	eet, factory, office		28f. Location (S	Street and N	umber or Run	al Route Numi	ber,
ă	al or safter	erti	4 ☐ Homicide determined building, etc	c. (Specity)				City or Tow	n, State)			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and planner sta	f examination								)
	To the within Го the хотры	Me	29b. Signature and title of certifier			29c. Licens	se number	:	29d. Date și	igned (Month,	Day, Year)	
			1			DS	708		10/1	3/0)		
,	.) @		30. Name and address of person who completed cause of d	eath (Item 23	Ba) (Type,	Print)						
de	1M 8		Kraig Melville, MD 110 Hospital Ro	Signature	0			78				
3	Sta Registi		31. Date filed (Month, Day, Year) 32. Registro  OCT 1 4 2009 ▶	ars Signature	A.	fall	¢.					

Physicia	an
/Medic	al
Examin	er

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any Injury or other traumatic event, If a Modical Exemiter must be notified at anones.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

den 20 St

1 - For State Registrar	State of Maryland	Certificate o	f Death	Reg	2009	3442
1. Decedent's Name (First, Middle, Las Jose David	Rivera			2. Date of Death Month October	7, 2009 Year	3. Time of Death 11:05 P M
4a. Facility Name (If not institution, given 1822 Battery La	·	4b. City, Town	or Location of Death		4c. County of Death  Calver	
5. Social Security Number 6. S 109–42–1574		st birthday) If Under 1 Yes  Yrs. Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, ) Dec 2. 1	Year) 9. Birthp	place (State or Foreign htry) to Rico
Usual Residence of Decedent  10a. State 10b. County  MD Calv		Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 💆 No
10e. Street and Number 1822 Battery La	ne	10f. Zip Code	20736	100	g. Citizen of What Cour	ntry?
MD Calv  10e. Street and Number  1822 Battery La  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No IfYes, Give Year or Dates:	13. Was Decedent of If Yes, specify C	f Hispanic Origin? (Spuban, Mexican, Puerto lo <i>Specify:</i> Pu	pecify Yes or No- Rican, etc.) erto Rica	14. Race - Americ Black, White, Specify: Whi	etc.
15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use ret	ne during most of work ired) -	sing 16	6b. Kind of Business/Ind	
		Management	18. Mother's Nam	e (First, Middle, Ma	_	
Jose A. Rivers 19a. Informant's Name/Relationship ( Micki Rivera (W	Type. Print)	19b. Mailing Address (Street 1822 Batter		ral Route Number, (	Pag City or Town, State, Zip <b>20736</b>	
20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specifi	20b. Pla	ice of Disposition (Name of metery, crematory or other p		Date 20 10	Oc. Location - City or To	
21. Signature of Fyneral Service Licen	see	22. Name and Ad	dress of Facility Le	e Funeral	Clinton, Home Calv Owings,	ert, PA
23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line.  a. Due to (1 as a const-que	Cateral	Sclerasia		st,	Approximate Interval Between Cnset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	·				
	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 Ectopic pregna	nncy		23d. Date of delive	ery Day Year
Part II. Other significant conditions of	ontributing to death but not resulti	ing in the underlying cause	given in Part I.		acco use contribute to the	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions of				24a. Was an autopsy performe 1 □ Yes 2	prior to co	psy findings available mpletion of cause of 2  No
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of Injury 2	28b. Time of 28c. Ir	Other: 4 Nursing He	th (Check only one) ome 5X Residen 28d. Describe how	ce 6 Other (Specia	(y)
1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier		Injury W M 1	/ork? □Yes 2□No		eet and Number or Rura	al Route Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	rysician: To the best of my knowl niner: On the basis of examination and manner stated.	ledge, death occurred at the on and/or investigation, in m	e time, date and place y opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as stee and place, and due to	stated. the cause(s)
29b. Signature and title of certifier  30. Name and address of person who	Payer Wy	0	ense number 4535	290	d. Date signed (Month,	
Catherine I. B		5 Town Cente	r Blvd. D	unkirk, M	ID <b>2</b> 0754	
OCT 1	3 2009 Deneur	B. Sparks				

	For State Registrar	State of Marylar	nd / Department of I Certificate of		ental Hygien Reg. N	2009	34428
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Las	Martha	Rideou7	or Location of Death	october	Pay Year 2009 c. County of Death	3. Time of Death
Funeral Director	5. Social Security Number 6. St. 215-36-0868	ex 7. Age (In yrs.	last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yea		Ster ace (State or Foreign ry) yy Land
With the Maryland as or 28a-1 show be notified at Director	7772 1001011	ester 10c. ci	ty, Town or Location	e	/		d. Inside City Limits 1
36 0 atter death or items 23 contenus 23 contenus 23 contenus 23 contenus 23 contenus 24 Funeral	10e. Street and Number  2 3 3 9	Noad Ap 12. Was Decedent Ever in U Armed Forces? 1Yes _ 2 [b]No If Yes, Give	1. 4-03 2/0 .s. 13. Was Decedent of liftes, specify Cub.	Hispanic Origin? (Specan, Mexican, Puerto Ri		24 S A  14. Race - America Black, White, et	n Indian,
d 21215-0036 d 21215-0036 liled within 72 hours aff they liene. they than "natural", or int, the Medical Exercition, the Medical Exercition of the M	3	Year or Dates:	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working		Kind of Business/Indo	essing
ryland iryland should be file and Mental H marked out mattic even	17. Father's Name (First, Middle, Last)  Charles  19a. Informant's Name/Relationship (1)	Davis, Sr.	J	18. Mother's Name (	First, Middle, Maide Jack	en Surname) SON	۸
ore, Mass 1 and 2 as 1 and 2 as 1 and 2 as 1 item 27 is rother trau	Shavon Ri  20a. Method of Disposition  1 Burial 2 Cremation 3 Company  4 Donation 5 Other (Specify	deout  Removal from State	1222011	on Road A	+pt.403(2	and bridge, Location - City of Tov	MD.21413
Baltime permit. Page Department Important: It any injury o	21. Signature of Funeral Service Licen  Parelle  23a. Part 1. Enter the disease, or comp	C. Henry	22. Name and Addre HENYY F 510 LVG	chington s	one, P.A st. Camb	ridge, MD	21613 Approximate
ficate be executed where the burial-transit is the burial-transit edical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any calling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sep	ses ligence on: l'Failell orend Ane	mie		) i	Interval Between Onset and Death
P.O. Box 687, nat the death certificate dby the attending physiciached for use as the by the sician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		23d. Date of delivery Month Day Year				
al Records, P.O.  The law requires that the decate has been signed by the page 2 should be detached completed by Physic	Part II. Other significant conditions or	ontributing to death but not res  LIS:  Couled	ulting in the underlying cause given the Central Centr	ven in Part I.		2 No 3 Proba	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	6 □ Other (Specify ury occurred	)				
To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29a. Certifler (Check only one)  Certifying Phymedical Exam  29b. Signature and title of certifier	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurred at the tation and/or investigation, in my	opinion, death occurred	d at the time, date a	(s) and manner as stand place, and due to	the cause(s)
State Registrar	30. Name and address of person who of the state of the st	ALLITER 32. Registrar's Signa	, 503/3	yan Stu	ert, Can	nbeidge	MD-2161

DHMH 17 Rev 1/2001

Physician /Medical Examiner

**Funeral** Director

Registrar	ertificate of		Reg. No.2 0 0			34429					
1. Decedent's Name (Fin	st, Middle, Las Evans	Ryan					2. Date of D Month Octobe	De	ay 20	Year 09	3. Time of Death 8:25 pt
a. Facility Name (If not institution, give street and number) Friends Nursing Home			4b. City, Town,		4c. C		County of Death  Montgomery				
5. Social Security Number		ex M 2 F	7. Age (In yrs.	last birthday Yrs.		If Under 24 Hr Hours Min	s. 8. Date of B	Day Year	27	9. Birth	place (State or Forei ntry) York
Usual Residence of Dec			100 6	10c. City, Town or Location							
10a. State 10b. County 10c. City,  Maryland Montgomery					Silver Spring						10d. Inside City Limit 1 ∐Yes 2 ️ XN
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country			ntry?
501 Fleetwood Street  11. Marital Status 12. Was Deced			edent Ever in U	ent Ever in U.S. 13. y		20910 Was Decedent of Hispanic Origin? (Spec			USA  14. Race - American Indian, Black, White, etc.  Specify: White		can Indian,
	Armed Forces?  1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates:				If Yes, specify Cuban, Mexican, Puerto Ricán, etc.)  1 □ Yes 2 ☑ No Specify:						
15. (Specify or					edent's Usual Occupation e kind of work done during most of working				16b. Kind of Business/Industry		
Elementary/Secondary (0-12) College (1-4or 5+)  12 College (1-4or 5+)  Teacher's Aide						Education			n		
17. Father's Name (First, Middle, Last) Claude Evans						18. Mother's Name (First, Middle, Maiden Surname) Florence Connolly			e)		
19a. Informant's Name/I Patricia R			nter	19b. Mail	ing Address (Stree	and Number or I	Rural Route Num	ber, City	or Town,	State, Zij	p Code) 20910
4 Donation 5 21. Signature of Funeral	Service Licen	See	22	2		ess of Facility Colling rsity B	.vd. W.,	al H Sil	ome I	Inc.	ing, Marylang, MD 209 Approximate Interval Between
23a. Part 1. Enter the dis shock, or heart fail Immediate Cause (Final	ure. List only	one cause on e	acn line.			ng, such as cardi	ac or respiratory	arrest,			Onset and Death
shock, or neart fall	ure. List only	a. Aspi	aused maneat ach line. ration (or as a conseq	Pneum		ng, such as cardi	ac or respiratory	arrest,			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition	ns,	Aspi Due to	acn line. ration (or as a conseq	Pneumounce of):		ng, such as cardi	ac or respiratory	arrest,			
Immediate Cause (Final disease or condition resulting in death)	ns,	a. Aspi Due to b. Cere Luntu c. Atri	acn line.  ration (or as a conseq	Pneumouence of): cular	onia Accident	ng, such as cardi	ac or respiratory	arrest,			Onset and Death
Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition and the cause. Enter Underlying Cause (Disease or injury that Initiated events	ns,	a. Aspi Due to b. Cere Luntu c. Atri	ration (or as a consequence brovasc (ur as a cunsequence	Pneumouence of): cular	onia Accident	ng, such as cardi	ac or respiratory	arrest,			years
Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition and the cause. Enter Underlying Cause (Disease or injury that Initiated events	ns, atte	b. Cere Cumbo  c. Atri Due to  d. 23c. If yes, out	come of pregnatation and at time of a	Pneumouence of): cular interpretation of the culture of the cultur	onia Accident	ey	ac or respiratory	arrest,	23d. Dati		years years
Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition and the cause (Final disease or condition resulting in death)  Sequentially list condition and the cause (Final death) cause (Final disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregint the past 12 month of the cause of the cau	ns, all	b. Cere Cun to Due to Atri Due to  23c. If yes, out 1	come of pregnant at time of cown	Pneumouence of): cular uence of): cillat uence of): ancy I death 3 Jeath 5	onia Accident ion □Ectopic pregnan □Other (specify)	гу	23e. Did		Moi	nth ribute to t	years  years  years  years  he cause of death?
Sequentially list condition resulting in death)  Sequentially list condition resulting in death)  Sequentially list condition resulting in death)  Sequentially list condition resulting in death)  Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregin the past 12 mont 1 □ Yes 2 ☒No 9 □ Unknown  Part II. Other significant	ns, all	b. Cere Cun to Due to Atri Due to  23c. If yes, out 1	come of pregnant at time of cown	Pneumouence of): cular uence of): cillat uence of): ancy I death 3 Jeath 5	onia Accident ion □Ectopic pregnan □Other (specify)	гу	23e. Did 1 L 24a. Wa aut	tobacco	Moruse contr	ribute to t  3 Pro  Were autorior to colleath?	years  years  years  years  bably 4 🗷 Unknown  psy findings availate  completion of cause of
Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition resulting in death)  Sequentially list condition of the cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent precipit the past 12 month of t	ins, and instant in the conditions of the condit	b. Cere Luntu  c. Atri Due to  d. 23c. If yes, out  1 Live 4 Preg 9 Unkn  Ontributing to de	come of pregnabirth 2 Feta nant at time of cown	Pneumounce of): cular unnec of): cular unnec of): cillat unnec of): ancy I death 3 Jeath 5 unting in the uniting  onia  Accident  ion  □Ectopic pregnan □Other (specify)  underlying cause gi	en in Part I.  26. Place of December.	23e. Did 1	tobacco Yes 2 Yes	Moruse control  2 □ No  24b. V p d o 1	nth  3 Pro  Were autorior to coleath?	years  years  years  years  years  bably 4 🖾 Unknow  ppsy findings availat  pmpletion of cause of  2 🗆 No	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition resulting in death)  Sequentially list condition and the cause (Final disease or condition resulting in death)  Sequentially list condition and cause. Enter Underlying cause (Disease or injury that Initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent preging the past 12 month of the past 12 mon	ins, and instant in the conditions of the condit	Aspi  a. Aspi  Due to  b. Cere  Cun to  C. Atri  Due to  23c. If yes, out  1   Live  4   Preg  9   Unkr  contributing to do	come of pregnabirth 2 Feta nant at time of cown	Pneumounce of): cular unnec of): cular unnec of): cillat unnec of): ancy I death 3 Jeath 5 unting in the uniting  Accident  ion  Ectopic pregnan Other (specify) underlying cause gi	en in Part I.  26. Place of Doer: 4 ☑ Nursing	23e. Did 1	tobacco  Yes 2  s an  ppsy formed?  2 K No	Moruse control 2 □ No 24b, V p o 1 6 □ Othe	nth  sibute to t  significant	years  years  years  years  years  years  year  he cause of death? bably 4 124 Unknow  ppsy findings availat  ompletion of cause of  2 □ No	

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Ellen Ritchie, MD

2901 Olney-Sandy Spring Road, Olney, MD 20832

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

			For State Registrar	State of Maryland			of Health a	nd Mental	Hygiene	2009	34430	
200	P. 63	Y:	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year									
	Physici /Medio		Vivian Emma Russe	ber 9,		3:00 A M						
	Examin	er	4a. Facility Name (If not institution, give s				m, or Location of	Death		. County of Death		
		5	Bethesda Health ar  5. Social Security Number 6. Sex		ast birthday)	Bethes		4 Hrs. 8. Date of	MC of Birth or, Day, Year)	ntgomery 9. Birth	place (State or Foreign intry)	
-	Funeral Director			M 2⊠F 82	Yrs.		ays Hours		n, Day, Year) 0/1926	ł .	intry) York	
2.4	D.		Usual Residence of Decedent		T1-				0, 200		10d. Inside City Limits	
	shov	5	MD 10b. County MD Montgomer		, Town or Lo :hesda						1 TyYes 2 □ No	
	the N	Director	10e. Street and Number	10f. Zip Code				10g. Ci	tizen of What Cou	untry?		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examinar mant terroillist at		4710 Bethesda Avenu	ıe Apt. 1318			0814		Unit	ed State	es	
	death	Funerai	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent	of Hispanic Orig	in? (Specify Yes of Puerto Rican, etc.	or No-	14. Race - Amer Black, White		
92	or ite		1X Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2√□			,	Specify: Whi		
Maryland 21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:		dent's Usual O			16b K	(ind of Business/l		
5	n na	Completed	(Specify only highest grade	completed)	(Give	kind of work de DO NOT use re	one during most	of working	100.11		,	
212	d with	E O	Elementary/Secondary (0·12)	College (1-4or 5+)	Cler.	ical			Fed	eral Gov	rernment	
9	be filed ital Hygi d other	Bec	17. Father's Name (First, Middle, Last)	1.1			18. Mother	's Name (First, M	iddle, Maider	Sumame)		
<u> </u>	should tund Ment	ဂ္	Irvine Justin Rus					ha Ann D				
Mar	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Typ					r or Rural Route N e Ant 1			MD 20814	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show appringury or other traumatic avent, the Medical Examinet man be relified at ance.		M. Ann Russell / S	20b. Pl	ace of Dispo	sition (Name o	of !	Date		ocation - City or 1		
<u></u>	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other Cremato		/13/2009	Fa1	1s Churc	h VA	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	T				Joseph G				
m	Department Department	1 8	W. Certh Miss	u	100			ve. NW W				
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on								Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	Athero scle	rotic	Cardi	ovasuela	an dise	ase.		Unknown	
ŭ	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):							
LAUMINIC		i.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
,60	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):							
876	ate be hysici the bu	licai	<b>€</b> d									
x 68	Attending Physician: The law requires that the death certificat robath.  cloath. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnar	ncv.					and Date of deli		
P.O. Box	attender for us	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregn Other (specif				23d. Date of deli Month	Day Year	
o.	the d	ysic	1 ☐ Yes 2 🗓 No 9 ☐ Unknown	9 Unknown		3 0 4 10 1 10 000 01/2	,,					
ر. ت	uires that signed b d be deta	y P	Part II. Other significant conditions con		•	nderlying caus	e given in Part I.	23e.	Did tobacco		the cause of death?	
Vital Records, I	w require been sig should b	ed b	Cerebrovasant		+				1 Yes 2	!□No 3□Pro	obably 4 Unknown	
900	lawre as bee 2 sho	Completed	atrial fib	rillasion				24a.	Was an autopsy	24b. Were au	topsy findings available completion of cause of	
œ .	The ate h	Som	Pleunal ef	Fusion				101	performed? (es 2 X N	death?	2 🗆 No	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
ot	Physi this c	. To	1 ☐ Yes 2 🖟 No						tome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
O	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ N			.,		
Division of	I or Attending Physician: The lav after death. Director: Atter this certificate has in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str	eet, factory, of	fice	28f. Locat	ion (Street a	nd Number or Ru	ral Route Number,	
ā	e agige	Cert	4 - Horricide	building, etc. (Specify	)			Chy	ir rown, stat	6)		
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in h		(Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat	vledge, deatl	n occurred at the	he time, date and my opinion, deat	d place, and due to h occurred at the	the cause(s	s) and manner as id place, and due	stated. to the cause(s)	
	the hin 24 the F	Medical	one)	and manner stated.			cense number			ate signed (Montl		
,	To wit		29b. Signature and title of certifier				043121			10/12/0		
	•		30. Name and address of person who to		23a) (Tune							
			NURUL CHOWD	releted cause of eath (Item	52/6	DINO D	RIVE!	BURTON	SUILLI	E, MIDO	20866	
9	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure							
2	Registi	ar	OCT 14 2009	Deneda A.	park	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 10, 2009 /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Montgomery Rockville 8. Date of Birth (Month, Day, Year)
Dec. 25, 1920 If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F Months New York Days Hours Director 88 119-09-8019 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Chevy Chase Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States 4601 N. Park Ave., # 1406 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No if Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🕱 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marvel Comics 4 Comic Book Letterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Zinkowetsky David Rosen ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 N. Park Ave., #1406, Chevy Chase, MD 20815 Emanuel Rosen, Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/12/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance Memorial Park Clarksburg, MD 21. Signature of Func r J Gervice License Torchinsky Hebrew Funeral Home Carroll St., NW. Washington, DC 20012 Emperine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest contact failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of was autopsy performed? 217 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 은 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number

P 454 36

29d. Date signed (Month, Day, Year)

OCTD13 6 D. 10, 2009 4 0 ONTROSERD, ROCKVILLE, MD 20852 Date filed (Month, Day, Year) State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 34432 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ REZNICK Friedel October 11, 2009 12:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kensington Rehab. Center Kensington Montgomery If Under 1 Year If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours 578-34-0795 Jamuary 19. 1929 CGERmany 80 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Kensington 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3000 McComas 20895 Ave. U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Who 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Nidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oscar Feuer Jeanette Kramm 19a. Informant's Name/Relationship (Type, Print) Steven Reznick / sor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $P0\ Box\ 101$  , Somers ,  $NY\ 10589$ son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \( \text{M Burial 2 \( \text{Cremation 3 \( \text{Denotion 5 \( \text{Capital Nat1}} \) \) Capital Hebrew Cem 10/13/2009 Capital Heights, Md. 4 Donation 5 Doner (Specify) Signature of Fundral Service 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., N.W., Washington, D.C. 20012 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or complication Approximate Interval Between Onset and Death shock, or heart failure. List only one of Immediate Cause (Final Ph sician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, Divisito (or as a nonsequence of cause. Enter Underlying Cause (Disease or linjury Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Pregnant at time of death 5 Other (specify) ed by the a detached f g 🗌 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 1 Unknown Alzheimers Dementia Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director.

29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death of	1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.							
(Check 2 ☐ Medical Examiner: On the basis of examination and/or investig	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state							
only one) 3 Certifying Nurse Practioner. To the best of my knowledge, de	eath occurred at the time, date and place, and du	e to the cause(s) and manner as stated.						
29b. Signature and title of certifier  MD	29c. License number D0064624	29d. Date signed (Month, Day, Year)						

Oct. 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2009

743 Summer Walk Dr., Gaithersburg, Md. 20878 Sandeed Sharma, 31. Date filed (Month, Day, Year)

State Registrar

Medical

**Physician** /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician

the signed by t

After this c

within 24 hours after deau.

To the Funeral Director:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or items 23a or 28a-f show

Director

Funeral

<u>Ş</u>

Completed

Be ပ

injury or other traumatic event, the Medical Examinar must be notified at

"natural"

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "any injury or other traumatic event, it a Medonce."

death with the Maryland

Baltimore, Maryland 21215-0036

SINGLA

Examiner Physician/Medical nis certificate has been s director, page 2 should Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
Part II. Other significant cond

Metabolic acidosus

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner\_of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗎 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

mo

29c. License number

Mospita

29d. Date signed (Month, Day, Year)

Glen Burnie, MD 2106/

30. Name and address of person ULT 31. Date filed (Month, Day, Year)

Sompleted cause of death (Item 23a) (Type, Print) ACOBS 32. Registrar's Signature

State Registrar

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ernest Clifford Senior 200°9 October 0 2:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel South River Health and Rehabilitation Center Edgewater Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖵 M 2 🗆 F Days Hours Min. Now 26 Day 1925 Peningy1vania 579-26-8603 83 **Director** Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director North Beach Maryland Calvert 1 🗆 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3801 3rd Street 20714 United States or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give 1 Yes 2 No Specify: "natural", 3 🗌 Widowed 4 🙀 Divorced Year or Dates. 43-45 Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) US Government carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Barber Ernest Clifford Senior 19a. Informant's Name/Relationship *(Type, Print)* Wade Senior — nephew -18b Mailing Address Street and Number or Rural Routy Number City or Town, State, Zip Code) 20b. Place of Disposition (Name of Chessiperate of High destricts of Men. 16714/2009 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State Port Republic, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home BRa 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Atheroscienotic cardiovoscular ditease Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions Examine if any, leading to influence cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Day Year ☐ Yes 2 ☐ No 9 🔲 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? syndrome 1 Yes 2 No 3 Probably 4 Munknown peen Storcture 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has completed filled in by the funeral director, page 2 performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 으 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Gartifying Numer Praction of T. the Section of the sect (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) yan.c. Surana. D 50653 10-12-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ムッド んしょこ SURBNA Churchton Deale Road Deale

State

Registrar

31. Date filed (Month, Day, Year)

2009

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760, Division of Vital Records,

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Patrick Spies 6, George October 2009 1503 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-Memorial Campus Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months Min 1 X M 2 □ F 64 Yrs. 217-42-6707 03/24/1945 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Director MD Allegany Corriganville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21524 USA 11725 Proenty Road, NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Textile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Henry Spies Rose Alice Logsdon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1267 Wills Church Road, Berlin, PA Carrie Sue Stock / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or ot 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Cumberland Crematory 10/08/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Cicensee laams 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 7, 2009 D09157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow, M.D., 124 West Third Street, Cumberland, MD Paul Snow, M.D., 31. Date filed (Month, Day, 32. Registrar's Signature State 8 Registrar

Amended #20b, nls, per fd, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10/06/09, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician WAYNE 10 630 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland MEMORIAL CAMPUS A Uegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country Months 1 M 2□ F 163-40-5712 62 Yrs. -22-4 MO Director Usual Residence of Decedent Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a are not any injury or other traumatic event. Implications any injury or other traumatic event. Implications any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Be Completed by Funeral Director PA Somerset HUNDMAN 1 ☐ Yes 2 ☑No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 153 USA PALO 15545 ALTO 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kestaurant owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emerick Shroyer ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HYNOMAN PA 15545 Shroyer PALO ALTO RO Beverlu 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 🙀 Removal from State HYNOMAN ea Comps Cem, 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 169 Clarence Harvey H. Zeigler F.H. INC Hyndinan PA 15545 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physlclan: The law requires that the death certificate be executed and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy ٥ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown in by the funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 M Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 25 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of eath Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. RANJIBHAN MD Rd 517 E. Oldtown Comberland MD 31. Date filed (Month, Day, Year) **QCT 0 6 2009** 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Sherman, Jr. Steven Bruce 12,2009 /Medical 4a. Facility Name (If not institution\_give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMH ampus 8. Date of Birth (Month, Day, Year) 01/27/1980 Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Min 1 ₹M 2 □ F 218-94-1874 29 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Directo Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 9 Lyons Street 26753 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Completed by Specify: 3 Widowed 4 Divorced White is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene 12 <u>Cabinet Maker</u> <u>Manufacturing</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kay Steven Bruce Sherman Susan Wolfe ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Julie A. Sherman / Wife 9 Lyons Street, Ridgeley, WV 26753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 10/15/2009 Cumberland, MD 21, Signature of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, reading to minimum accuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) signed by the a P.0. 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a. Was an autopsy performed' certificate 2 No 2 1No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 □ Nб 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28c 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

nds

1221 National Highway, LaVale, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,

32. Registrar's Signature

Shiv C. Khanna,

31. Date filed (Month, Day, Year OCT 13 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician nnar /Medical 4b. City, Town, or Location of Deat Facility Name (If not institution, give street as Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Hours Min. Months Days 4.42.853 Marylano Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Marylan 28a-f shov d other than "natural", or items 23a or 28a-f shorevent, the Medical Evantimer must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 2 1613 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufactur permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if item 27 is marked other tha any injury or other traumatic event, Its 1000s. 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Ylvester ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type/Print) Mbr. dge, MD. 2/6/3 enve laann 20c. Location - Oity or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 17/09 ew Revived Cemetery Taylors Island 4 □ Donation 5 □ Other (Specify) 22. Name and Address of acility HENRY Funeral 510 Washing 21. Signature of Funeral Service Licensee MD.21613 io washington st. Cambridg 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, transfer underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Do 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No this certificate 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 ☐ DOA 1 Inpatient 1 Yes Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury After 1 (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No death. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number

within 24 hours after death To the Funeral Director: completely 0

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certified

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Sampson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worceste 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Mgnth, Day. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**₽**M 2□ F Days Hours Min. 118 48 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Bucks 10e. Street and Number 10g. Citizen of What Country? 18940 186 **23a** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □Yes 1 Never Married 2 Married 2 1 No Specify. Yes, Give چ ک Whit-3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 5+ College (1-4or 5+) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) Senior Vice President Beam Pines- NY, NY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Sampson Joan Bertsche 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trainone. Susan M. Sampson (daughter) 186 Andrew Drive Newtown, PA 18940 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2009 | Frankford DE Cape Henlopen Crem. 22. Name and Address of Facility The Burbage Funeral Home f Funeral Service Loc 108 William St Berlin, MD 21811 23a. Part 1/Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Light only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner whire Cordinary posting Esquentially list on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Vear 5 ☐ Other (specify) 1 ☐Yes 2 ☐No cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Division of Vital 1 ☐ Yes 2 12 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \Bigcap \) Nursing Home \( 5 \) \( \Bigcap \) Residence \( 6 \Bigcap \) Other (Specify) 2 12 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Sampson To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MChelle 76K 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month Cctober Anna Kathryn Starliper 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 220-16-2812 20,1925 Pennsylvania Feb. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√2 No Maryland | Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11922 Sun Valley Dr. U.S.A. 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify Specify: White 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Frederick Goetz Bessie Wallach Goetz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Hartsock-daughter 16719 Caldwell Ct. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 10-17-2009 | Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Fastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) smally asdie Due to (or as a consoquence of): anings Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of) Cot Due to (or as a consequence of): metabolie If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Yea Day 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

<u>\$</u>

Completed

Be

ည

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It at ItealCal Exymination is the ricitified at any once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

or Attending Physician:

death. after death

To the Hospital within 24 hours a To the Funeral D

JH-L

Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar certificate completely filled in by the funeral director, After this

Physician/Medical ≥ Completed Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 14√0

29b. Signature and title of certifier

26 Place of Doath (Check only one)

	Hospital: ↑ Inpatient 2	ER/Outpatient	3 🗆 0	OOA Other:	4 ☐ Nursing H	lome	5 Residence	6 ☐ Other (Speci	ify)
'n	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M	28c. Injury at Work?	2 □ No	28d.	Describe how inju	ary occurred	
111			(4)	TLITES	2 🗀 140				_

29c. License number

27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 6 ☐ Could not h 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

126 Mikaun CI Hershon MD 21740 opel

State Registrar

Medical

31. Date filed (Month, Day, Year) 00T 1 6

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of He State Registrar Certificate of D			iene eg. No. 🧳	000	01.15
ı	Physici		1. Decedent's Name (First, Middle, Last)  Ida S. Shankman		2. Date of Deat October		. U U 3 009 <sup>ear</sup>	3. Time of Death 12:35Р м
all ag	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L Chevy Cha				nty of Death	у
	Funeral Director		577-03-2398 1□ M 2  F 95 Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 06/30/1	Year) 914	Count	ace (State or Foreign try) ington, DC
	Maryland -f show	tor	Usual Residence of Decedent  10a. State				10	0d. Inside City Limits 1 A Yes 2 □ No
	h with the	al Director	10e. Street and Number 10f. Zip Code 8101 Connecticu Avenue, Apt. 614 20815			0g. Citizen o	of What Count	ry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar mast be notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:  1 □ Yes 2 ☒ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		lace - America lack, White, e cify: Wh:	tc.
Maryland 21215-0036	vithin 72 hou sne. :han "natura .v m.dical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Condition 16a. Decedent's Usual Occupat (Give kind of work done during life. DO NOT use retired)  Owner	uring most of working	ng		Business/Ind	ustry and Drug
land 2	uld be filed w Aental Hygie rked other t tic event, It.	To Be Co		18. Mother's Name Anna Ch	(First, Middle, I			and brug
, Mary	and 2 shoulealth and Now 27 Is main her traumal	( d)	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Section 19b. Mailing Address)  19c. Mailing Address (Street and Section 19b. Mailing Address)	Ave., Ap	ot. 508	Chev	y Chas	e, MD 20815
Baltimore,	t. Pages 1 rtment of H rtant: If iter rjury or oth	100	20a. Method of Disposition  1⊠ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of National Capitol Hebrew Cemetery)	10/00/	/2009	Capi		ights, MD
Ra	permi Depar Impor any ir	1 10	21. Signature of Funeral Service Licenses Pan Zan Sky - G 1170 Rockvi	.lle Pike	Rockv	ille,	els, I MD 208	52
lating	Physician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.  Immediate Cause (final disease or condition resulting in death)  Pneumonia  Due to (or as a consequence of):	, such as cardiac o	r respiratory arr	est,	2	Approximate Interval Between Onset and Death Weeks
8760,	certificate be executed rding physician and ise as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Classas or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):					
O. Box 6	eath certi attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown				Date of delive Month	ry Day Year
rds, P.	w requires that the d s been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.		bacco use co es 2 <sup>™</sup> No		e cause of death? ably 4 🗌 Unknown
al Records,	The la ate has page 2	Completed			24a. Was a autops perform		b. Were autop prior to cor death? 1 ☐ Yes	osy findings available npletion of cause of
of Vital	Physiclan this certifi ral director	: To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	4 L Nursing Hor		ence 6 🗆 0		()
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 ☑ Natural 5 □ Pending (Month, Day, Year) Injury Work?	es 2□No		treet and Nu		l Route Number,
	he Hospit. in 24 hours he Funera pletely fille	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the best of examination and/or investigation, in my opinand manner stated.					
	2-0	Σ	29b. Signature and title of certifier 29c. License D0983				ned ( <i>Month, I</i>	
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Barry N. Rosenbaum, MD 3720 Farragut Avenue	Kensingto	on, MD 2	20895-	2110	
	Sta Registr	- 3	31. Date filed (Month, Day, Year)  OCT 1 4 2009  Leven D. Fauls  OCT 14 2009					

DHMH 17 Rev 1/2001

09-08110								
Jason S	Sanders							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jas	son Sanders		1- For State Registrar	S	tate of Maryla	and / L	epartm <i>Certific</i>			Menta	al Hyg		g. No. 2	n	9 31.1.1
Ma	Physici dical Exam		Decedent's Nar									Date of Death Month	Day Year		3. Time of Death 1904 hrs
ivie	fuicai Exaiii	mer	Jason 4a. Facility Name	Phili (if not institution	p Sanders on, give street and no	ımber)		- 14b.	City, Town, or L	ocation of		October 18	4c. County of	Death	1904 MS
			Easton Me			,			Easton				Talbot		
	Funeral Director		5. Social Security	Number	6. Sex	7. Age (li	n yrs. last birl		If Under 1 Year Months Days	If Under:	Min		(MM/DD/YYYY)	Foreign	
	Director		220-63- Usual Residence		1 X M 2 F		7	Yrs.	Morialo Bayo	110010		06/26/	2002	Cour	ntry) Maryland
	any		10a. State	10b. County		100	c. City, Town	or Location				-		1	10d. Inside City Limits
e	land f show	or	MD		1bot		F	aston					1 Yes 2 X No		
750	Mary rr 28a-	Director	10e. Street and N		1- D1			1	Of. Zip Code			10	g. Citizen of Wha		ry?
_	death with the Maryland or Items 23a or 28a-f show must be notified at once.		10573 L		12. Was De	redent Eve	er in IIS	13 Was F	21601 eccedent of Hisp	anic Origin	2 / Speci	fy Ves or No-	USA 14 Page		an Indian, Black,
	death v r ltem nust be	uneral	1 X Never Marr		Arried Armed F			If Yes,	specify Cuban,	Mexican, F	Puerto Ric	an, etc.)	White,		arrindan, black,
	s after ral", o	by F	3 Widowed		vorced If Yes, Give Ye	аг			es 2 X No				Specify:		ite
	5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	leted	15. Decedent's E Elementary/Sec		ecify only highest gra	de comple 1-4 or 5+)	ted) 16a.	Decedent's during most	Usual Occupation of working life.	on (Give kir DO NOT us	nd of work se retired)	( done )	16b. Kind of Bus	iness/In	dustry
	036 ithin 7 me. r than	Comple	2	, , , , , , , , , , , , , , , , , , , ,	0	,		Stu	dent				Elemer	ıtar	y School
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	е Со	17. Father's Name						1				aiden Surname)		
	2121 uld be fil Mental B marked	To B		Jeffrey Alan Sanders  8a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip								Zin Code)			
	MD 12 sho th and 127 is		Jeffrey	Alan Sa	anders/fat	her	-						n, Maryl		
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis	-	n 3 Removal f	rom State	20b. Place		n (Name of cem			ate	20c. Location -		
	timent creations or other		4 Donation 5	Other S	Specify:		Spri	ng Hi			10/24	4/2009	Easto	n, l	Maryland
	Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked o injury or other traumatite event, th		21. Signature of F			ر سره د	)		lows. He	,	bein	& New	nam Fune	ral	Home, P.A.
	Physician			he disease, or		aused the	death. Do no								21601 Interval
,	/Medical caminer		Immediate Cause	(Final disease	e on each line. e a <b>Vir</b>	al sy	ndrom	е							Between Onset and Death
1			or condition result		Due to (or as a	conseque	ence of):								
		ner	Sequentially list or if any, leading to it cause. Enter Und	mmediate	Due to (or as a	conseque	ence of):								
		Examine	(Dissuss of Irjury events resulting in	that initiated	Due to (or as a	conseque	ence of):								
	ecuted and - transi	al E	- 37		d										
	tox 68760, eath certificate be executed e attending physician and for use as the burial - transit	Medical	X UNPENDED	· · · · · · · · · · · · · · · · · · ·	AMENDED				ıE, g897	11/1	L7/09	TT			
	3876 rtificat ing phy as the	an/M	IF FEMALE: 23b. Was decedent past 12 month	t pregnant in t	he 23c. If yes,		of pregnancy 2		death 3	Ectopic p	oregnancy	1	23d. Date of o	delivery Da	ay Year
	Box 687 death certific the attending p	Physician/	1 Yes 2		4 Pregr	nant at time			(Specify)						
	that the d ned by the detached		Part II. Other sign	ificant condi	tions contributing t		it not resultin	g in the und	erlying cause gi	ven in Part	I.	23e. Did to	pacco use contrib	oute to th	ne cause of death?
	ires that the signed by	d by	Cereb	ral pa	1sy_							1 Yes	2 No 3	Proba	bly 4 🗸 Unknown
	Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed										24a. Was a autops			ppsy findings available mpletion of cause of
	II Reconn: The land tifficate has tor, page 2	Som										perform 1 <b>Y</b> Yes 2		eath? ✔ Yes	2 No
	ital Reician: The scertificate rector, page	Be	25. Was case reference examiner?	rred to medica	Hoenital:				10	of Death (Co					
	1 of V ling Phys After thi funeral di	£	1 ✓ Yes 27. Manner of Dea	2 No	' ' '	of Injury Day,Year)	2 🗸 ER/O	Time of Injui			Nursing H		Residence 6 ow injury occurre	Other:	
	ion (tendin eath.	Certification:	1 X Natural 2 Accident	5 Pend	ding estigation	ı, Day,Year)			1 Y	es 2 N	10				
	Division At ours after d teral Direct filled in by	tific	3 Suicide	6 Cou	ld not be 28e. Plac	e of Injury	- At home, fa	arm, street, f	actory, office bu	ilding, etc.	28	f. Location (S		r or Rura	al Route Number, City
	Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the		4 Homicide 29a. Certifier	1	rmined (Specify)						- 1				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only		hysician: To the best miner: On the basis	of examina									
	To It	Me	29b. Signature and	title of certifie	and manner s	tated.			29c. License	number			29d. Date signe	d (Mont	h, Day, Year)
			Car	de,	4012	200	_		O.C.N	1.E.			October 19,	2009	
			30. Name and add		who completed caus		'	Penn Str	eet, Baltimo	re MD 1	21201				
	St	ate	31. Date filed (Mon	th, Day, Year)	32/. Re	egistrar's S				. C, IVID 2	- 1201				
	Regist	_		CT 21	מיגו ממממ	in	B. 1	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:08 PM MARILYN RUTH STOKES 2009 OCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CENTREVILLE 130 WILSON CLARK LANE 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Year) 1965 WEST VIRGINIA Hours 1 🗆 M 2 🕱 F JUNE 22, Director 236-02-3879 44 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2X No QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral 130 WILSON CLARK LANE 21617 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 2 **X** No þ 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify. 3 🗌 Widowed 4 🗆 Divorced Completed WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 and Mental Hygie is marked other Be Department of Health and Mental H
Important if item 27 is marked ott
any injury or other traumatir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ALMA VANMETER CHARLES L. JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 WILSON CLARK LANE, CENTREVILLE, MD 21617 COSBY M. STOKES, III/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. PETER S CEMETERY 10-13-2009 QUEENSTOWN, MD Fineral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCLEROSING CHRANGETT Physician/ disease or condition Medical resulting in death) Examiner CERAPIU Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No. 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No ၉ 1 Yes 1 Inpatient 2 Inpatient 3 Inpatient 2 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Matural 5 Pending within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🕏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed of ause of death (Item 23a) (Type, Print) 629 RAILROAD AVENUE, CENTREVILLE, MD 21617

State Registrar ERIC F. CIGANEK,

31. Date filed (Month, Day, Year)

M.Ø.,

32. Registrar's Signature

DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34444 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2,2009 5:30 $\mathbf{A}^{M}$ OCTOBER Medical **Examiner** 4a. Facility Name (inhot institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death QUEEN ANNE'S 104 TILGHMAN AVE., APT. 109 CENTREVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Days DEC 21, Year 929 Months Hours Min. MARYLAND Director 79 218-24-4271 Usual Residence of Decedent Show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director -28a-f 1 X Yes 2 □ No QUEEN ANNE'S CENTREVILLE MD 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 104 TILGHMAN AVE., APT. 109 21617 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give 1948-1952 Year or Dates: Black, White, etc. þ 1 X Never Married 2 Married 21215-0036 hours after 1 ☐ Yes 2 👿 No Specify "natural" Specify. Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) WATERMAN SEAFOOD 10 -0-Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked o LYDIA BICKLING ELI SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 304 KERR AVE., DENTON, MD 21629 BETTY CLARK/ SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p. MARYLAND VETERAN CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10-6-2009 HURLOCK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death YEAR Physician/ disease or condition resulting in death) PROBABLE LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death par Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> SEVERE COPD 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION page 2 autopsy performed? Yes 2 ☑ No 2 🗌 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No NA 2 Accident 3 Suicide 4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined N Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check

State Registrar 29b. Signature and title of ce

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENCARNIT SANTOS-TECSON, 830 CHESAPEAKE DR., CAMBRIDGE, MD 21613

Box 68760

P.O.

Records,

of Vital

Division

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

20058667

29d. Date signed (Month, Day, Year)

10/2/0

The law requires that the death certificate be executed P.O. Box 68760 of Vital Records, Hospital or Attending Physician: Division death. after death filled in by the 24 hours a To the within 2

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Mont

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Alan Rohrer, M.D. 15 W. 7th Street Frederick, MD 21701 Registrar's Signatur 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

D37197

29c. License number

29d. Date signed (Month, Day, Year)

October 9, 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 34446 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11, **Physician** October 2009 2:43 A M Grady Leroy Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia 6022 Stevens Forest Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, 5 Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours Min 1940 Pennsylvania 1 X M 2 □ F 69 188-32-3313 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 14 health and Mental Hygiene. 15 marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examinating to notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21045 6022 Stevens Forest Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: African 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction 12 (unk) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Clark Curtis Smith ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6022 Stevens Forest Rd. Columbia, MD 21045 Betty W. Smith/wife item 27 other to Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any Injury or ot 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Final Journey Crematory 10/13/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21, Signature of Funeral Service License Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 alle Approximate Interval Between Onset and Death 3 years Part 1. Enter the disense, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final years Prostate Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Ye ar Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No The 2 🗆 No 1 ☐ Yes certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death ne Hospital or Attending Pi n 24 hours after death. ne Funeral Director: After t After t Injury 5 Pending investigation 1X Natural 1 ☐Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 October 12, 2009 D41139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Drive Suite G020 Columbia, MD 21044 Clement B. Knight, M.D. 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 ear **Physician** OCTOBER HAWA SAHID 11:25A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day SEPT 15 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1965 FREETOWNE SIREFA 1 □ M 2 😾 F Months Days Hours Min. 217-43-5935 44 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Y Y⊟Yes 2 □ No Director MD PRINCE GEORGE'S BOWIE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 11305 KENCREST DRIVE Funeral 20712 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 No ş Specify 3 Widowed 4 Divorced Specify: BLACK "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 12th College (1-4or 5+) HEALTH CARE PRIVATE marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Be 2 SAIDU SAHID KAMARA NIMATA GABISI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Health ALHAJI SHERIFF ALGHALI/BROTHER 5407 85th AVENUE # 102 LANHAM, MARYLAND 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State MD National Cemetery 8/16/2009 LAUREL, MARYLAND 4 Donation 5 Dother (Specify) of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) STATUS EPILEPTICUS /Medical Due to (or as a consequence of) Examiner CEREBRAL METASTATIC DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of BREAST CANCER or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HUMAN IMMUNODEFICIENCY VIRUS TYPE I INFECTION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 27 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred After Injury at Work? 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical d manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52503 OCTOBER 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAILESH SHITH M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 State **OCT 1 4 2009** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 Mary D. Trittipoe October 9:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 630 Biggs Ave Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Davs Hours Min. 08/11/1910 Maryland Director 220-34-1153 99 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland notified at Director MD Frederick 1X Yes 2 No Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? event, the Medical Examiner must be by Funeral 23a 21701 United States 630 Biggs Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decesson
Armed Forces?
Yes 2 XNo 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) self-employed farmer farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o 2 Darr Howard Daisy Grant traumatic t. Page 1 and 2 should by tment of Health and Mer chant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8001 Broken Reed Ct., Frederick, MD 21701 Wayne Eyler / grandson other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or injury or Olivet Cem. 10/24/09 4 Donation 5 Other (Specify) Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral ICL MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 20 40 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnapleted filled in by the funeral director, page 2 should be detached for use as the burnapleted filled in by the funeral director, page 2 should be detached for use as the burnapleted filled in the page 2 should be detached for use as the burnapleted filled in the page 2 should be detached for use as the burnapleted filled in the page 2 should be detached for use as the burnapleted filled in the page 2 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be detached for use as the burnapleted filled in the page 3 should be a sh P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Tes Investigation 2 🗌 No Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifi

Registrar

DHMH 17 Rev 7/2009

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BONGON AM love Site 140- FRE DERICH MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

MEMUM

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_aurell Taylor		tment of Health and Mental Hy ificate of Death	ygiene Reg. No. 2 N	00 2111							
Physician Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year	3. ≇me of Beath 4 0744 hrs							
Wedical Examine	Laurell Elizabeth Taylor  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 8, 2009  4c. County of Deatl								
	Carroll Hospital Center	Westminster	Carroll								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.	Forei	an l							
— Director	<u></u>	8 Yrs.	Aug 23, 1951 C	ountry) CA							
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, 1	Town or Location		10d. Inside City Limits							
Maryland 28a-f show any d. at once,	MD Carroll Westm	inster		1 X Yes 2 No							
the Maryland a or 28a-f sh	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	intry?							
vith the	820 Medinah Circle 11. Marital Status 12. Was Decedent Ever in U.S	21158  13. Was Decedent of Hispanic Origin? ( Sp	USA pecify Yes or No. 14 Race - Amel	rican Indian, Black,							
r death with or items 23	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto		Tour mount, Drawn,							
s after or iral", or niner m	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2X No specify:	Specify:Whit								
2 hours	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		/Industry							
5-0036 ed within 72 houn lygiene. other than "natu he Medical Exan		Attorney	City Gover	nment							
filed w Hygie d othe	17. Father's Name (First, Middle, Last)  Jack Reynolds Brown		(First, Middle, Maiden Surname)								
ould be find the property of t	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or F	June Trousdale Rural Route Number, City or Town, State	e, Zip Code)							
MD 12 sho th and 127 is	James Richard Taylor/son	538 Old Bachmans Vall	ey Rd. Westminster	, MD 21157							
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important If tiem 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1 Burial 2 V Cremation 3 Removal from State cr	ace of Disposition (Name of cemetery, ematory or other place)	Date 20c. Location - City o								
t. Page tment rrant:	4 Donation 5 Other Specify: Fin	al Journey Crematory 1									
Bal permi Depar Impo	21. Signature of Funeral Service tricensee  AUVILLY THE HEALTH MO1	Going Home Cremati	on Service P.O. E	80x 784							
Physician	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac of	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and							
/Medical ⊂xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
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Š	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
= 1	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
e be executed ysician and burial - transi	d.										
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that the death certification by the attending pheatched for use as the by the Dhucician M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	23d. Date of delive Ancy Month	Day Year							
box 6876  the death certificate by the attending pheched for use as the	1 Yes 2 No 9 Unknown g Unknown	th 5 Other (Specify)									
P.O. E es that the d igned by the detached	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?							
S, P.C	Î		1 Yes 2 No 3 Pro								
Records, The law require ficate has been significate has been significate has been significate has been significate has been significated.			autopsy prior to	utopsy findings available completion of cause of							
ital Recician: The last certificate herector, page de Com	<u> </u>		1 Yes 2 No 1 Y								
fital sician: sician: is certilirector	25. Was case referred to medical examiner?  Hospital: Inpatient 2	26.Place of Death (Check ER/Outpatient 3 DOA Other;  Other;  Nursin	only one) ng Home 5 Residence 6 Othe	er.							
Division of Vital Records, rat or Attending Physician: The law require is after deand, all birector: After this certificate has been sitled in by the funeral director, page 2 should be retification: To Be Completed	1 V 163 2 1NU	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
Division o spiral or Attending ours after death. Ineral Director: After filled in by the function or Attending or Attending our after a filled in by the function.	1 ✓ Natural 5 Pending 2 Accident Investigation	1 Yes 2 No									
Divisi  pital or Att ours after de leral Direct filled in by	3 Suicide 6 Could not be 28e. Place of Injury - At hor	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	tural Route Number, City							
lospitz 4 hours unera	29a. Certifier	e death occurred at the time, date and place, and	due to the cause(s) and manner as sta	ited							
To the Howithin 24 h To the Funcompletely	(Check only one) 2 Medical Examiner: On the best of my knowledge and manner stated.										
F 3 F 8	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mi	onth, Day, Year)							
	JM. Re	O.C.M.E.	October 8, 2009	<del>}</del>							
'5	Name and address of person who completed cause of death (Item: Jack Titus MD.     Deputy Chief Medical Examiner	<sup>23a)</sup> 111 Penn Street, Baltimore, MD 2	1201								
Stat	31. Date filed (Month (Day, Year)) 0000 32. Registrar's Signatur	0.0									
Registra	061 I 4 2009 Lenun	3. parks									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 00 Mari 0 /Medical 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick 8. Date of Birth (Month, Day, Year) July 17, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 172-18-9226 90 **Director** Pennsylvania Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Frederick Walkersville 72 hours after death with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Crum Road 21793 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates: White þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natuany injury or other traumatic event. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. Store Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Hetrick Mary Callahan ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Veitch/Daughter 22 Crum Road, Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place)
Red Lion
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 23, Red Lion, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Well kuna 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dement **Physician** 7100 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes P.O. the 2. PNo detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 DNo Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura! 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Shah

31. Date filed (Month, Day, Year)

32. Registrar's Signature

hamas

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / De State of Maryland / De State	•	rtment of H <i>tificate of L</i>		-	giene Reg. No.		21151	
	Physici		Decedent's Name (First, Middle, Last)  Vinh Phat Vo				2. Date of De Month Octobe		, 2009 , 2009	3. Twee detail 6:55 P M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Casey House	$\top$	4b. City, Town, or Rockvill			4c. County of Death Montgomery			
	Funeral Director	П	5. Social Security Number  213-41-5515  6. Sex 1 M 2 □ F  7. Age (In yrs. last birth)  7. Age (In yrs. last birth)		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb 18	th		place (State or Foreign ntry)	
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of  MD Montgomery Montgomer					10d. Inside City Lin			
	with the 3a or 28a It be not	Il Direc	10e. Street and Number  10228 Millstream Drive	1	10f. Zip Code 20886			10g. Cit	izen of What Coul	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and to notified a once.	by Funeral Director		If	J Vas Decedent of Hi Yes, specify Cuba □Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specity:	pecify Yes or No Decify Yes or No Decify Yes or No Decify Yes	)-	14. Race - Ameri Black, White, Specify: Asia	etc.	
215-0036	thin 72 hour he. han "natural"	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Give k life. D	ent's Usual Occupa kind of work done o O NOT use retired	luring most of worl	king		ind of Business/In	dustry	
yiang 21	be filed wintal Hygier d other the	Be	17. Father's Name (First, Middle, Last)	ck (	Clerk	18. Mother's Nam		, Maiden	cery Sto	re	
Maryia	12 should th and Mer 7 is marke traumatic	2	1 1 1 1		g Address (Street a		ral Route Numb	er, City c		c Code)	
saitimore, i	ages 1 and int of Healt t: If item 2: / or other		20a. Method of Disposition  1 Rurial 2 VCremation 3 Removal from State	Dispos , crema	sition (Name of atory or other place	e) :	Date	20c. Lo	ocation - City or To	· =	
Бани	permit. Pa Departme Important any injury		4 □ Donation 5 □ Other (Specify) Final 5  21. Signature of Funeral Service Licensee  Alberta Land Mo1251	<b>ර</b> ී	rney Cren Nagan Addres	"Crematio	n Servi	.ce	P.O. Box		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Liver Cancer  Due to (or as a consequence of)	ot ente					27.5 V111	Approximate Interval Between Onset and Death	
8/60,	icate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease u. in jury tresulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.									
.O. BOX 62	law requires that the death certhing as been signed by the attending pl 2 should be detached for use as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)	/			23d. Date of deliv Month	very Day Year	
ras, r	quires that in signed b ild be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	he und	derlying cause give	en in Part I.				the cause of death?	
al Records,	icate has bee page 2 sho	Completed					24a. Was auto perfo 1 🗆 Yes		prior to co death?	opsy findings available ompletion of cause of	
vision or vital	To the hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1  Inpatient 2  ER/Outp  27. Manner of Death 1 Natural 5 Pending investigation  28a. Date of Injury (Month, Day, Year)  28b. Tir		28c. Injury Work	v at		idence		in)hospice	
DIVIS	cal or Atter s after dea al Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, stre	et, factory, office		28f. Location ( City or To	Street ar wn, State	nd Number or Rur e)	al Route Number,	
	ne Hospil in 24 hour he Funera pletely filli	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death /or inv	occurred at the ting estigation, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time	e cause(s , date an	s) and manner as d place, and due t	stated. to the cause(s)	
1	Voith To th	Ž	29b. Signature and title of certifier  J. Kouertchou, m.D.		29c. License	number 3748			te signed (Month, ober 12,		
	b		30. Name and address of person who completed cause of death (Item 23a) (Tocelyne Kouatchou, M.D., 6001 Munca			Rd. Rocky	ville, M	D 20	855		
	Sta Registr		Od Date filed (Month Day Van)		arkel		•				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

		-	State Registrar				Cer	tificate of L	Death		Re	g. No.			
			1. Decedent's Name (F	irst, Middle, Lasi	t)						2. Date of Death Month		Year	3. Time of I	Death
	Physicia /Medic		CHARLES		М.			WIL	SON		OCTOBER	16,	2009	1:05	A M
	Examin		4a. Facility Name (If no	t institution, give	street and number)			4b. City, Town, or	Location of	of Death		4c. Cour	nty of Death		
			FOREST HII	L HEALT					REST						
	Funeral		5. Social Security Numb		7. Age		yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min.					Year)	Count	ace (State of	-
ы.	Director		200-18-9	135 -	X	83	Yrs.				Month, Day, 7/12/1	926	Mar	ÿland	
	and w		Usual Residence of De 10a. State 10	b. County		10c. City, To	own or Loc	cation				-	10	d. Inside Cit	y Limits
	raryli r sho	ö		ontgome	rv		Lav	tonsvil	le					1 □Yes	2 <b>X</b> No
-	28a-	Director	10e. Street and Numbe				1	10f. Zip Code			10	g. Citizen o	of What Coun	try?	
3	Mith Ba of		21700 G		ıgh Road			2076	O:				US.	A	
	Jeath	Funeral	11. Marital Status		12. Was Decedent B			Vas Decedent of H	ispanic Ori	gin? (Spec	ify Yes or No-		Race - America		
٠	or Ite		1 Never Married	2X Married	Armed Forces? X⊟Yes 2⊟N If Yes, Give	<sub>10</sub> 1951	-   "	fYes, specify Cuba □Yes 2 <b>X</b> No	n, Mexicar Specify:		ican, etc.)		Black, White, e cify: Whi		
8	ral",c	b	3 ☐ Widowed 4 ☐	Divorced	Year or Dates:	52			эреспу.			Spe	city: *****		
2	illed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural", or Items 23a or 28a-f show ther than "natural", or Items 21a or 28a-f show ent, the Marileal Everylant or must be mailful at an ent.	Completed	15 (Specify o	. Decedent's Ede	ucation de completed)	1	(Give I	lent's Usual Occup kind of work done o	during mos	t of working		6b. Kind of	Business/Ind	ustry	
21215-0036	han '	ם	Elementary/Seconda	ry (0-12)	College (1-4or 5	+)		OO NOT use retired ' <b>mer</b>	2)			Aari	cultu	re	
2	Hygie hert hert	ပိ	17. Father's Name (Firs	et Middle Last)	4		rai	mer	18 Mothe	er's Name i	(First, Middle, M				
au	ed of	Be	William		all Wils	on			Ali	,		chus	•		
<u> </u>	mark matic	ဍ	19a. Informant's Name				19b. Mailin	g Address (Street						Code)	
Maryland	s 1 and 2 should be blied within 72 hours after death with the Marylan of Health and Mental Hygiene. If the alth and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventral at matter with the Medical Eventral at matter with the Medical Eventral at matter with the Medical Eventral at matter and the matter at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral at the Medical Eventral Eventral at the Medical Eventral Even		Mary Bev	, ,		1		Rocks						1132	
<u>υ</u> .	F Hea		20a. Method of Disposi			20b. Place	e of Dispos	sition (Name of natory or other place	20)	Da	ite 2	20c. Locatio	on - City or To	wn, State	
<u>۾</u>	ages ento rt: If i		XXBurial 2 ☐ C 4 ☐ Donation 5 [		Removal from State	Hig	hlan	d Cemet	ery	10/2	1/09	Stre	et, M	aryla	nd
altimore,	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of Fune		<del></del>		22	. Name and Addre	ss of Facilit	ty			173	14 _	_
ä	an per	10	C. Kal	est to	Unsa		H	arkins	Fune	ral	Home,	Inc.	, Déi	tā, P	Α
			23a. Part 1. Enter the o	disease, or comp	olications that caused	the death. [	Do not ente	er the mode of dyir	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Bety	, veen
- P	hysician	- 11	Immediate Cause (Fin		one cause on each in	e.	UZVENICO:	1 July						Onset and D	eath
	/Medical		disease or condition resulting in death)		a Due to (or as	a consequen	ice of):	1 Amil	W.						
E	Examiner				diatie	lea									
	. +	ner	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or inju- that initiated events	diate	Due to (or as	a consequen	ice of):								
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Ŏ,	oe exe ian a urial-		resulting in death) Last		Due to (or as	a consequen	ice of):								
68760,	cate on the party of the party	Medical			.d										
φ ×	ding page as	-	IF FEMALE:		23c. If yes, outcome	of pregnancy	·					004	Date of dollar		
P.O. Bo	atten for us	by Physician	23b. Was decedent pre in the past 12 mo	nths?	1 Live birth	2 Fetal de	eath 3□	Ectopic pregnanc Other (specify)	ÿ			230.	Date of delive Month		/ear
o ]	the check	ysic	1 □Yes 2 □N 9 □ Unknown	0	9 Unknown	t time or <b>dea</b>	5	Joures (Specify)							
σ.	mar red by detac	H.	Part II. Other significa	nt conditions co	ontributing to death b	ut not resultin	ng in the ur	nderlying cause giv	en in Part I		23e. Did tob	acco use c	ontribute to th	e cause of d	eath?
Vital Records,	ulres u sign ld be	d b								1	1 □ Ye	s 2 N	o 3 Prob	ably 🖎 L	Jnknown
8	h red	Completed									24a. Was ar	n 24	4b. Were auto	psy findings a	available
E E	ne lav e has ige 2	E G									autops perform	y ned?	prior to cor death?	inpletion of ca	ause of
<u> </u>	s certificate has birector, page 2 sl		25. Was case referred	to medical					26 Place	e of Death	☐ 1 ☐ Yes 2 (Check only one	e)	1 🗆 Yes	2 NO _	
<b>&gt;</b>	/sicia s cert direct	o Be	examiner? 1 ☐ Yes 2 No	ŀ	Hospital:	ent 2 □ ER	R/Outpatien	nt 3 DOA Oth	ar: \		ne 5 🗆 Reside		Other (Specif	v)	
Division of	g rn er thi	n:T	27. Manner of Death		28a. Date of Inju		Bb. Time of Injury	28c. Injur Wor			8d. Describe ho				
<u>o</u>	ath. r: Aff	atio	2 Accident	5 ☐ Pending investigation		y, reary	,,		Yes 2□	No					
S S	er de recto by th	ti	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home c. (Specify)	e, farm, stre	eet, factory, office		2	8f. Location (St. City or Town	reet and Nu , State)	mber or Rura	l Route Num	ber,
	rs aft ral Di led in	Certification: To	4												
	to the hospital or Attending Prysician: The law requires that the deam cermicate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2	Certifying Phy Medical Exam	ysician: To the best niner: On the basis o	f examination	edge, deatl n and/or in	h occurred at the ti vestigation, in my o	me, date a opinion, de	nd place, a ath occurre	and due to the c ed at the time, d	ause(s) and ate and pla	d manner as s ce, and due to	tated. the cause(s	)
	the the the the the the the the the the	Medical	one)	of partities	and manner sta	ated.		29c. Licens	e number		2	9d Date ei	gned (Month,	Day Year)	
	0 1 ₹ 0	-	29b. Signature and title	e or certifier										. ,	
			and a	3 12		and the second	0a) /T:		2235		0	cloty	n 15,	2004	
	15		30. Name and address DAVID DUN		completed cause of d				AIR, 1	MD.	21014				
	Sta	te	31. Date filed (Month,												
	Registr		SET 27	2009	annual 1	ar's Signatur	Silla								

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

MARY VIRGINIA WEITZELU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

OCTOBER

19,

2009

4c. County of Death

12:50P<sup>™</sup>M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1104 Cortense 2009 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis, MD Medical com Anndel Anne If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🕽 F June 24, 1933 Director MD 217-30-1062 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Chesapeake Beach Calvert MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 20732 USA Funeral 6536 9th Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 2 3 Widowed 4 □ Divorced Black Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other tha any injury or other traumatic event, ITell ODG. 12 Federal Government Admin. Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be ဂ Caleb Sherbert Mary Geneva Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan R. Smith-Sharps - stepdaughter 20a. Method of Disposition 20b. Place P.O. Box 608, Owings, MD 20736 Baltimore, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Olive UM Church Cem. October 16, 2009 Prince Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Bladys 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (visease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed and Due to (or as a consequence of): burial-Box 68760 attending physician Physician/Medical as yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day ō in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pneumonia page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No Division of Vital e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Donpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1/ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide \*\*Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2.

the

è

2001 medical Parkway, 31. Date filed (Month, Day, Year) State 142009 Registrar

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Anndel medical Center

Annapolis.

29c. License number

MO

769566

21401

29d. Date signed (Month, Day, Year)

10/10/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2009 seorge war ashington Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Easton

order 1 Year If Under 24 Hrs. +OSPice Talbot If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 № M 2 🗆 F 220-32-181 Sept. 26, 1935 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Tal Laston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 60 was becedent Ever in U.S. Armed Forces? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: 3 ₩Widowed 4 Divorced 1ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) avetaker rivate 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sac ဥ Hazel Johns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 21601 11:ams 2930 Wav Jak Ston Howard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Persville Cometery 4 □ Donation 5 □ Other (Specify) 117/09 Easton 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENry Funeral Home, KAY SIOWASHINGTON ST. CAMbri MD. 21613 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) amle Glish YZUIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): Box 68760, cate has been signed by the attending physician, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 🗹 Natural 5 ☐ Pending investigation I hours after death.

uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

the within To the

> State Registrar

(Check only

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

82

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Laurel Yolande Williams 10/07/09 0210 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/06/1950 7. Age (In vrs. last hirthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F 59 Director Indiana 578-68-8605 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Modical Examinar must be r 20032 4614 Livingston Rd. SE # 204 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 q 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Employee Government of Health and Mental Hygie fitem 27 is marked other in other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Earthan Carson Eunice King 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Briana S. Williams-Preston 304 Creste Drive Decatur, GA 30035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Oct. 14, 2009 Washington, DC 4 ☐ Donation = 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lic. ns -22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washigton, DC 23a. Partice Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorragic Shock /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Massive Upper Gastro Intestinal Bleed burial-tran death certificate be exect Due to (or as a consequence of) Physician/Medical the I as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 9 Unknown Š signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Chronic Liver Disease Due to Hepatitis C 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page certificate 1 ☐ Yes 2 ☐ No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital

Box 68760, P.O. I of Vital Records, Division

State

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0061937

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CANDACE L. WILSON, MD - 1500 FOREST GLEN RD, SILVER SPRING, MD

29a. Certifier

Medicai



and manner stated.

Registrar

09-07919 Carroll D. Young

# Please Type or Print in Black Indelible link / Ensure All Copies Are Legible.

Carroll D. Young	1-1	State of Maryland / Departn or state Certific	nent of cate of	Health and Death	d Mental Hy	rgiene Reg. N	. 20	90 211E
Physician/		tistrar Decedent's Name (First, Middle,Last)				2. Date of Death	<u> </u>	6. Time of Beath 4
Medical Examiner	ì	Carroll Donell Vo	UV	9		Month Day October 12, 2	009 4c. County of Death	0909 hrs
7	48	Facility Name (if not institution, give street and number) Franklin Square Hospital	1	1b. City, Town, or Rosedale	Location of Death		Baltimore Cou	
Funeral	5.	Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	If Under 1 Yea	r If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or
Director	1	14-42-9199 1VM 2DF 65	→ Yrs	Months Day	s Hours Min.	Dec 18	8-1444 CC	untry ary land
-	U:	ual Residence of Decedent						10d. Inside City Limits
w any	10	a. State 10b. County 10c. City, Tow						1 VYes 2 No
rland once.		MD Baltimore Ba	Itin	10Ye		10g. (	Citizen of What Cou	ntry?
the Maryland of a or 28a-f sh tiffed at once	"			212	36		USA	
with the Maryl ss 23a or 28a-		6 Durban Court  Marital Status 12. Was Decedent Ever in U.S.	13. Wa	s Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	14. Race - Ame White, etc.	ican Indian, Black,
ar death with or items 23. Funeral	1	Never Married 2 Married Armed Forces?  1 Yes 2 No		_/	n, Mexican, Puerto	Ricall, etc.)		2011
ral", o	<u>ا ا</u>	Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No	specify: ition (Give kind of v	vork dane 16	Specify: 6/	
"natu	$\vdash$	5. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	during m	ost of working life	e. DO NOT use reti	red)		
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed		12	BUS	5 Dr	iver_	7	ranspo	rtation
21215-0036 21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medica To Be Comple		'. Father's Name (First, Middle, Last)			//	1	den Surname)  Won o	7 <
ID 21215-( should be filed \tau and Mental Hygi 7 is marked oth natic event, the To Be Cc	3 -	a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stre	Bern et and Number or	Rural Route Numbe	r, City or Town, Sta	e, Zip Code)
MD 21 ad 2 should alth and Me m 27 is ma aumatic ev		Miona T. Voung	6 D	urban	Courts	Balti Mor	e Marylo	100 21236 r Town, State
e, N. I and Health Health ritem		na Method of Disposition / 20b. Plac	e of Disponatory or of	sition (Name of ce ther place)	emetery,	Date 2	0c/Location - City o	r Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. To the first 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		Donation 5 Other Specify:	leaso	int Ceme	etery 10/	19/09	Salem, N	lary land
Baltimore, MD 212 pernit. Pages I and 2 should be Department of Health and 75 is mark important: If item 27 is mark injury or other traumatic even	2	I. Signature of Funeral Service Licensee	22. I	Name and Address	on eral	Home, P. A	Salen, N Mbr. dge	MD.21613
	2	Ba. Parl I. Enter the disease, or complications that caused the death. Do	not enter	the mode of dying	Shing To.	or respiratory arrest	shock, or heart	
Physician Medical	1	failure. List only one cause on each line.						Between Onset and Death
aminer		nmediate Cause (Final disease r condition resulting in death)  a. Multiple science for Due to (or as a consequence of):	010					
	.   5	equentially list conditions, any, leading to immediate b. Due to (or as a consequence of):						
led Insit		Disease or injury that initiated C.						
ecuted and and transit	N	vents resulting in death) Last  Due to (or as a consequence of):  d.					_	
	3 -	X UNPENDED AMENDED 23a,27,pe	rmE.	¢898 12	/4/09 TT			
760, cate be exphysiciar he burial		FEMALE: 23c. If yes, outcome of pregnar	ncy				23d. Date of deliv	ery Day Year
Box 6876( he death certificate rethe attending physhed for use as the b		b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death		etal death 3 Other (Specify)	Ectopic pregr	iancy	Mona	July 1
Box e death c the atten ed for us	<u>&gt;</u>	Yes 2 No 9 Unknown 9 Unknown					a contributo	to the cause of death?
irres that the dates the date of de detached de detached de de detached de de de de de de de de de de de de d	-   F	art II. Other significant conditions contributing to death but not resu	ulting in the	underlying cause	e given in Part I.			robably 4 Unknown
S, P. Puires t						. 24a. Was an	24b. Were	autopsy findings available
Records, The law require: ficate has been sig, page 2 should be						autopsy perform	ed? death	
Rec The l ficate l	5			26 Pla	ce of Death (Chec	1 Yes 2	No 1 🗸	Yes 2 No
Vital Records. ysician: The law requirements in secretificate has been director, page 2 should	ן מֿ	5. Was case referred to medical examiner?  Hospital: Inpatient 2 F	R/Outpatie		Tour		esidence 6 Ot	her:
of Vital Records, Jing Physician: The law requir After this certificate has been s funeral director, page 2 should		7. Manner of Death 28a. Date of Injury (Month Day Year)	8b. Time o		njury at Work?	28d. Describe ho	w injury occurred	
ion: A the fu		1 X Natural 5 Pending			Yes 2 No			2 12 11 11 11 12 12
Division spital or Attendit hours after death. meral Director: A y filled in by the fire	υl	Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, str	eet, factory, office	e building, etc.	28f. Location (Stror Town, Sta		Rural Route Number, City
		4 Homicide determined (Specify)  9a. Certifier 1 Certifying Physician: To the best of my knowledge	dooth occ	surrod at the time	date and place at	nd due to the cause	(s) and manner as s	stated.
Division  To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	رم ا	one) 2 Medical Examiner:On the basis of examination and	l/or investig	gation, in my opini	ion, death occurred	d at the time, date a	nd place, and due to	the cause(s)
To Viid	ğ -	9b. Signature and title of certifier	Mes	29c. Lice	ense number		29d. Date signed (	Month, Day, Year)
		Tula Vallen Jeg		0.0	C.M.E.		October 13, 2	009
	t	10. Name and address of person who completed cause of death (Item 2	3a)	Penn Street	, Baltimpre, M	D 21201		
		Victor Weedn MD JD Assistant Medical Examine  11. Date filed (Month, Day, Year) 32. Registrar's Signature			, Datambre, W			
Stat Registra		OCT 21 2009 June	A. A	barris				

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Tracey Lamar Ar		eWS 1- For State	State	of Maryland /	•			nd Mental	Hygiene		200	9 31.1.1
Physicia		Registrar  1. Decedent's Name (Firs	t Middle Last	`	Certifi	icate of Dea	atn ———		2. Date of	Reg. No.	200	
Medical Examir		TRAC		<i>'</i>	A	NDRE	W.	5		Day er 20, 20	Year	3. Time of Death 1455 hrs
1		4a. Facility Name (if not i		e street and number)				r Location of De			c. County of Death	
ì		University Hospi				Bal	timore				N	IA
Funeral Director		5. Social Security Number		, and the second	(In yrs. last t		nder 1 Ye		£ .	,	/DD/YYYY) 9. Birl Foreig	n .
Birector		220-94-11	/ /	M 2 X F	4/	Yrs.			9-	11-6	28 Co	untry) N.C.
any	1	Usual Residence of Dece 10a. State 10b. (	County	1	10c. City, Tov	vn or Location						10d. Inside City Limits
*	5	MD	-RFIT	ERICK		F	DE	DERI				1 Yes 2 No
Maryl:	Director	10e. Street and Number	1	0	4	10f. 2	Zip Code			10g. Cit	izen of What Cour	ntry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once,	Ē	609 H	ME	SHV1=	101	6	21	703			U5 1	7
death wi	Funeral	11. Marital Status 1 Never Married 2	Married	12. Was Decedent E Armed Forces?	<b>*</b>			ispanic Origin? ( in, Mexican, Pue			<ol> <li>Race - Ameri White, etc.</li> </ol>	can Indian, Black,
fler de		3 Widowed 4		1 Yes 2	No	1 Yes	2 <b>X</b> No	o specify:			Specify: 13/	ACK
1215-0036 Id be filed within 72 hours after lental Hygiene. narked other than "natural", event, the Medical Examiner.	d by	15. Decedent's Education	on (Specify on	or Dates: ly highest grade comp	oleted) 16	a. Decedent's Usu	al Occupa	ation (Give kind		16b.	Kind of Business/I	ndustry
6 n 72 h an "n ical E	leted	Elementary/Secondary	(0-12)	College (1-4 or 5-	+)	during most of v	vorking life	e. DO NOT use	retired)	1,	7112-11	
5-0036 led within 7 Hygiene. other than the Medica	Comple	17. Father's Name (First,	Middle Leet\			SPRUL	MI	VIKNU	7-1-K	1	SHNL.	146
215- be filed ntal Hyj rked of	Be C	17. Fattler's Name (First,	IA IV	HAI	1004	2		18.Mother's Na	ime (First, Midd	die, Maiden	V///	- <
ID 21215-00; should be filed within and Mental Hygiene. T is marked other than instite event, the Med		19a. Informant's Name/Re	elationship (Ty	/pe, Print ) / / 13 5	AND	19b. Mailing Addre	ess (Stre	et and Number	or Rural Route	Number, C	City or Town, State	
MD d 2 shulth and alth and are mat		MATHONY	HND	NULS II		009 HIN	12.25	AVET	106 F.K	10/15	RICK IM	1. 21803
more, M Pages 1 and 2 lent of Health int: If item 2		20a. Method of Disposition  1 X Burial 2 Creation	n emation 3	Removal from Stat	e crem	e of Disposition (Natory or other plac	ce)		Date		Location - City or	•
		4 Donation 5 O	ther Specify:		BI	OWNA			1-26-0	0.4		ILLE, N.C.
Baltir permit. I Departm Importa injury o		21. Sgnature of Funeral	Service Licens	Bus	41	22. Name at	nd Addres	ss of Facility	owner	PEUI	VERH	House
Physician	4	23a. Part I. Enter the dise	ease, or compli	ications that caused th	ne death. Do	not enter the mod	e of dving	such as cardia	c or resolirator	v arrest, sh	ock, or heart	Approximate Interval
/Medical		failure. List only one Immediate Cause (Final o	cause on ead	ch line. Forso I <b>njurie</b> s					<i>v</i>		/	Between Onset and Death
xaminer	-	or condition resulting in d	4le \	Due to (or as a conseq	quence of):							
	<u>.</u>	Sequentially list condition if any, leading to immedia		Oue to (or as a conseq	uuonaa af\;							
	Examiner	cause. Enter Underlying	Cause		dence or,							ļ
ecuted	Ä	events resulting in death)	Last C	Oue to (or as a conseq	juence of):							
6 H H .	<u>g</u>	UNPENDED		AMENDED							<del></del>	
ox 68760, sath certificate be ex attending physician for use as the burial.	ĕŀ	IF FEMALE:		23c. If yes, outcome	of pregnance	СУ				23	d. Date of delivery	
687 certific nding	ian/	23b. Was decedent pregna past 12 months?	ant in the	1 Live birth 4 Pregnant at til	me of death	2 Fetal deat		Ectopic pre	gnancy		Month E	Day Year
Box 68760, e death certificate be the attending physic ed for use as the burn	Physician/Med	1 Yes 2 No 9	<b>✓</b> Unknown	9 Unknown	ine or death	5 Other (Sp	pecify)					
		Part II. Other significant	conditions	contributing to death I	but not result	ing in the underlyi	ng cause	given in Part I.	23e. C	oid tobacco	use contribute to	the cause of death?
S, P	ed by								_ 1_	Yes 2 ▶	No 3 Prob	ably 4 Unknown
ord w req as bee	plet								_ a	Vas an utopsy	prior to c	topsy findings available ompletion of cause of
Rec The la	Completed									erformed? es 2 N	death? No 1 ✔ Ye	s 2 No
Division of Vital Records, tal or Attending Physician: The law require as after death.  Bircroor: After this certificate has been siled in by the funeral director, page 2 should be as a fire of the funeral director.	Be (	25. Was case referred to examiner?		osnital .				of Death (Che				
of V	앍	1 Yes 2 N 27. Manner of Death	No	ospital: 1 Inpatient 28a. Date of Injury		Outpatient 3	DOA 28c. Init	ury at Work?	sing Home 5		ence 6 Other	:
on on cending ath.	틸	1 Natural 5	Pending	Oct 20, 2009	<sup>nr)</sup> 12	20 hrs		Yes 2 ✓ No	Driver au			
ivisior  or Attendath after death Director;	<u>≅</u>	2 Accident 3 Suicide 6	Investigation Could not be	28e Place of Injur	ry - At home,	farm, street, facto	ry, office	building, etc.			and Number or Ru	ral Route Number, City
Ospital ospital hours a uneral I	· > 🛏	4 Homicide	determined	(Specify) Loca	l Street				Ballenger	vn, State) Creek Pik	ke & Rt 340, Fre	derick, MD
				n: To the best of my li On the basis of exami								
To the within To the comple	ᇙᆫ	29b. Signature and title of		and manner stated.	Tidilott dilato			se number			Date signed (Mor	
	_	anos	2					M.E.			tober 22, 2009	
		30. Name and address of	person who co	empleted cause of dea	ath (Item 23a	)						
		Ana Rubio MD.		t Medical Examir		Penn Street,	Baltim	ore, MD 212	.01			
Stat Registra	te <sup>3</sup>	31. Date filed (Month, Day	Year) 2U	32. Registrar's	Signature	parka	9					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of			giene Reg. No.2	009	3445		
Physic /Med		1, Decedent's Name (First, Middle, Last)	A	dam	<b>S</b>	2. Date of De Month		Year	3. Time of Death		
Funera Director	iner I	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospe	(In yrs. last birthday) 59 Yrs.		Location of Death  MOVO  If Under 24 Hrs.  Hours Min.	h	4c. Coun	9. Birthple Count Mary1	ace (State or Forei		
		Usual Residence of Decedent	10c. City, Town or Loc	cation		nay +,	1730		d. Inside City Limit		
e Mary la-f sho	ctor	MD	Balti						TX□Yes 2□N		
with th	1 Dire	10e. Street and Number 922 Quantril Way		10f. Zip Code	01005		10g. Citizen o		ry?		
ems 23	Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. V	Vas Decedent of H Yes, specify Cuba	21205 ispanic Origin? (S	pecify Yes or No	- 14. Ra	ace - America			
ours after ral", or it Exemin	b	1 Never Married 2 Married 1 TYes 2 No	· I	□Yes 2X No	Specify:	o nican, etc.)	Spec	ack, White, et ify: whi			
should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Modical Examinar mast be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give I life. D	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor. )	king	16b. Kind of		,		
al Hygi al Other	Be	17. Father's Name (First, Middle, Last)	Carp	enter	18. Mother's Nam	ne (First, Middle,	home i		ements		
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	5	Audis Adams	<u>,                                      </u>		Nellie I						
and 2 ealth a n 27 is		19a. Informant's Name/Relationship (Type. Print) Ella Mae Adams/spouse		Quantri				n, State, Zip ( . 205	Code)		
permit. Pages 1 Department of H Important: If iter any Injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)		ition (Name of atory or other plac	e)	Date	20c. Location	- City or Tow	n, State		
Depart Import any in		21. Signature Fineral Service Lensee Ronal 1. 8. Wards Direct		Name and Addres ate Anato ltimore,	omy Board		Baltin	nore St	reet		
Physician pe executed / Medical physician and street street is the prival-transit street in the prival street is the prival street in t	edical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate 0 use (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  b.  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tie 9 □ Unknown	Fetal death 3 ne of death 5	Ectopic pregnancy Other (specify)			М		yay Year		
een signed b	ed by	Part II. Other significant conditions contributing to death but r		errying cause give	n in Part i.		es 2 □ No		cause of death? bly 4 🗌 Unknov		
ate has b	Completed					24a. Was a autop perfor 1 □ Yes	sy ]	Were autops prior to compleath?	sy findings availab pletion of cause o		
r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Impatient	2 ☐ ER/Outpatient	3□ DOA Othe	26. Place of Deat						
within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral or	Certification: T	27. Manual of Death  1 Natural 5 Pending (Month, Day, Y)  2 Accident investigation	28b. Time of	28c. Injury Work' M 1 1	4 LI Nursing Ho	28d. Describe h  28f. Location (S  City or Tow	ow injury occur	rred	Route Number,		
within 24 hours after death  To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one)  1 Certifying Physician: To the best of reacher and manner state.	ny knowledge, death	occurred at the tim	e, date and place, inion, death occur	and due to the	acuso(s) and m	nanner as sta , and due to ti	ted. he cause(s)		
within To th comp	Me	29b. Signature and title of certifier		29c. License			29d. Date signe		*		
Sta Registr		30. Name and address of person who completed cause of deat  Shena-fu Lo The Jo  31. Date filed (Month, Day, Year)  32. Registrar's	hns Hopkin		al Ba	ltimore,	MD	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34460 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 12:10A M aniel Ctober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Months Days Hours Min Month, Day, Year an 5, 19 California Director 69 578-52-3320 1940 Jan Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2X☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 9739 Larkspur Lane 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced ntal Hygiene. ced other than "nature c event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) management is marked other automotive Be permit. Page 1 and 2 should be filed i Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Daniel Anthony Joanna Dareos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Anthony/spouse 9739 Larkspur Lane Hagerstown MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature Euneral Serv 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 irector Baltimore, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, heart 4 days Conjustive Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Other (specify) Month Day ☐ Pregnant :
☐ Unknown cate has been signed by the a page 2 should be detached in Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Her, tobaccophuse, 1, Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2X No 1. Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 24 hours after deat Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical 29a. Certifier ZCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Tu Bui

31. Date filed (Month, Day, Year)

Huger shown

arke

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DPAI

4

Registrar's Signature

10/25/

217 40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #20a-c.22, perFh 9897 11/4/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year Toni Lynn Allen 11:30 AM 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Min 215-82-2109 50 Director July 29, 1959 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show MD Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5143 Cedgate Road 21206 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or income any injury or other traumatic event and income. 7 Is marked other than "natural", or items traumatic event, the World Event 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No black ģ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 assembly person Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Allen ပ Helen Williamson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aubrey Williamson/brother 5522 Daywalt Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Greenmount Crematory 10/28/2009 Baltimore, MD

22. Name and Address of Facility Calvin B. Scruggs Funeral Hone ctor

State Anatomy Board 655 W. Baltimore Street 4 □ Donation State 21. Signed to of Funeral Truce Licensee Director <del>21201</del> 21213, 1412 E. Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final disease or condition resulting in death) Physician Preumonic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s certificate 2 No 1∐Yes 2∐No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after over To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lecritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number AT 2438946 B6 10, 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice Union Memorial 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 _ State	Department of Health and I  Certificate of Death		
		Registrar  1. Decedent's Name (First, Middle, Last)		Reg. N	3. Time of Death
Phys /Me		Farhat	Ali	OCTOBER D	22 2009 11:45PM
Exan	iner	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death  Baltimore	1 4	c. County of Death
Funer	ıl	5. Social Security Number 6. Sex 7. Age (In yrs. last		8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
Directo	r	N/A 1⊠M 2□F 79	Yrs. World's Days Flours Will.	06 15	30 India
aryland show			own or Location		10d. Inside City Limits
e Mar Ba-f sh	ctor	MD Howard	Elkridge		1 □Yes 2 X No
with th	Dir.	10e. Street and Number 5859 Whisper Way	10f. Zip Code <b>21075</b>	10g. C	Citizen of What Country? Indis
death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exerciper must be notified at	Be Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1	1 ☐Yes 2 No Specify:	o Ricari, etc.)	Black, White, etc.  Specify: Asian
5-0(72 houndered	eted	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business/Industry
121 within ene.	JQ III	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use relired)  Director	ung	Bank
ifled v Hygir other	ပို	12th grade 4yrs+ 17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maide	en Surname)
ylan buld be Menta arked	일	Irshad Ali		oda Begum	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminations must be notified at			9b. Mailing Address (Street and Number or Ru 859 Whisper Way, E		
Ore, es 1 a of Hea if item		20a. Method of Disposition 20b. Place ceme	of Disposition (Name of terry, crematory or other place)	Date 20c.	Location - City or Town, State
Itim		4 □ Donation 5 □ Other (Specify) K1ng	Memorial Park 10,	/23/09 W	oodlawn, Md
Ba perm Depa Impo		21. Signature of Funeral Service Licensee	March F/H West 4300 Wabash Ave	Baltimo	re, Md 21215
		23a. Pay 1. Enter the disease, or complications that caused he death. Described the shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physicia /Medica		Imprédiate Cause (Final disease or condition resulting in death)  A Due to (or as a consequence of the condition of the condi	noirhagic Stroke monary Embolish		2 days
Examine		Sequentially list conditions	monary Embolish	ru	1 week
det ted	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consequence).	pe of):		
execu	Examiner	that initiated events c	ee of):		
68760, Ep lificate be executed g physician and as the burial-transit	dical	d			
± 50 €	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
P.O. Box at the death cer by the attendire stacked for use	by Physician/Me	in the past 12 months?  1 \[ \text{Live birth} \ 2 \] \[ \text{Fetal death} \]  1 \[ \text{Ves} \ 2 \] \[ \text{No} \]  1 \[ \text{Ves} \ 1 \] \[ \text{Ves} \ 1 \]			Month Day Year
P.O nat the d by th	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting	s in the underlying enuise signs in Part I	220 Did tobacco	use contribute to the cause of death?
Division of Vital Records, or Attending Physician: The law requires thafter death.  Director: After this certificate has been signe of in by the funeral director, page 2 should be d		Fart ii. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part i.		2 No 3 Probably 4 Dunknown
aw req	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
The I	Com			autopsy performed? 1 □Yes 2 ☑	death?
Vita siciani certiffi rector,	Be	25. Was case referred to medical examiner?  1 Yes 2 15 No Hospital: 1 Tippatient 2 T EB/	Other:	th (Check only one)	
g Physer this seral di	n: To	27. Manne of Death 28a. Date of Injury 28b	Outpatient 3 DOA Marsing H  Time of 28c. Injury at Work?	ome 5 Residence 28d. Describe how inju	
Sior lendin eath. or: Aff the fur	catio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 ☐Yes 2 ☐No	<u> </u>	
Divi	Certification: To	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Division of Vital Records, P.O. Box (To the Hospital or Attending Physician: The law requires that the death certifulful or Attending Physician: The law requires that the death certiful to the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowled and manner stated.  29a. Certifler (Check only one)  29a. Certifler 29a. Certifler 29a. Certifler 29a. Tertifler 29a.	and/or investigation, in my opinion, death occu-	rred at the time, date at	nd place, and due to the cause(s)
To the within: To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
		* Kaft	A7243891	16	0/22/2009
2		and manner stated.  29b. Signature and tiple of certifier  30. Name and address of person who completed cause of death (Item 23-  KON (CLI H) TK-AR , M - D , UN (  31. Date filed (Month, Day, Year) 32. Registrar's Signature	a) (Type, Print) ON MEMORIAL HOSE	ITAL, Br	gLTIMERE, MD, 21218
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1. parl	- ,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2009 10 arnest /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL Baltimore SAMARITAN If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 237-40-1522 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Exp. in an must be muffied at once. 1 Yes 2 □ No Director altimore M 10g. Citizen of What Country? 10e. Street and Number rest 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) rind 18. Mother's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) Saltimore, Maryland Be ပ Pb. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 19a. Informant's Name/Relationship (Type. Pript)

Minnie Banks Sign Fica 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Doad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of crising, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC SHOCK Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. 9 I Inknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by COIRCINOMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DISEASE autopsy DIABETES 1 ☐ Yes 2 No 2 2NO 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 24 hours after death.

Funeral Director; Afterely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000

State

DHMH 17 Rev 1/2001

Registrar

OKTAI

31. Date filed (Month, Day, Year)

ORIGINAL

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

mam esor

Registrar's Signature

COED

SAMARIT AN

HOSPITAL BALTIMORR

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 2. Date of Death Month Decedent's Name (First, Middle, Last) Physician OCTUBER 2 2009 /Medical <u>Margaret May Birmingham</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake
Social Security Number 6. Sex Anne Arundel Arnold
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5/10/25 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🗷 F Maryland Director 219-16-8874 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County items 23a or 28a-f show 1 XYes 2 □ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2207 Langley Street Funeral 21230 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. ģ 3 ₩ Widowed 4 Divorced "natural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Office Building <u>Janatorial</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once. Be Abraham Bossum Edna Halfpenny ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Geraldine Impallaria / Friend 1133 S. Bonsal Street Baltimore, Maryland 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Souther (SpecifyEntombment Loudon Park Cemetery 10/28/09 Baltimore, Marvland 21. Signature of Euneral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) ications that caused the weath. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. **Physician** CORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🔀 No □Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation after death. 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month, Day) Registrar

32. Registrar's Signature

Veter and Kiery

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601

**ORIGINAL** 

millarsorth, my 21/08

DHMH 17 Rev 1/2001

09-08293 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maureen Butler State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 25, 2009 1835 hrs **Medical Examiner** Butler Maureen 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 3014 Pinewood Avenue Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Months Davs Hours Director 10/10/1960 49 068-50-1284 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Baltimore 28a-f shor items 23a or 28a-f shoust be notified at once. MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country U.S.A. 21214 3014 Pinewood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after death wit partment of Health and Mental Hygione.
portnant. If I (Iten 27 is marked other than "natural", or items? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes Specify: White 1 Yes 2 No specify: Divorced If Yes, Give Year <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Finance Stock Brokers Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gloria M. Paolini Be John J. Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) East Amhurst, NY 14051 192 Bramblewood Lane <u>ynn M.</u> Larson Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 10/27/2009 Woodbine, MD Final\_Journey Crematory Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services Box 1413 Moushoul P.0. Baltimore, MD 21203 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical a Cocaine and alcohol intoxication Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED 23a, PII, 27, 28a-f, permE, G897 11/6/09 TT XUNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 1 Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown 9 Unknown the P.O. F page 2 should be detached contributing to death but not resulting in the underlying cause given in Part I. þ Atherosclerotic cardiovascular disease Completed Records, 24a. Was an autopsy death? performed? Yes 2 ~ Be

certificate has To the Hospital or Attending Physician: funeral director, **Division of Vital** After this the

ို

Certification:

**Medical** 

29b. Signature and title of certifier

Russell Alexander MD.

n 24 hours after death. filled in by within 2. State

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other<sub>4</sub> Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 ✔ Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural Yes 2X No unk 5 Pending Fd 10/25/09 Fd 1835 hr 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3014 Pinewood Ave 3 X Could not be Suicide (Specify) residence Baltimore, MD 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

NY

Death

29d. Date signed (Month, Day, Year)

October 26, 2009

Assistant Medical Examiner

32. Registrar's Signature

**ORIGINAL** 

30. Mame and address of person who completed cause of death (Item 23a)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 3:10PM Physician Brown October 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Assisted Living Emerald Estates Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 7. Age (In yrs. last birthday) Security Number 6. Sex **Funeral** Days NC Months Hours 1 ☐ M 2 🕶 F 28 212-22-6647 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It. Medical Exprise must be puffind at once. 1 □Yes 2 No Baltimore Pillesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Hawthorne Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Black Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Medical Elementary/Secondary (0-12)

Hh Grade College (1,4or 5+) Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kosie Enoch Spence ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 219 Hawthome Avenue Pikesville MD 21208 William F. Brown Huoband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Baltimone, MD 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmount Crematory 10/29/09 4 ☐ Donation 5 ☐ Other (Specify) Vaugn C. Greene Funeral SVO 21. Signature of Funeral Service Licensee Iberty Road Randay stown MD 21133 Vaugh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) ed by the a 9 Unknows 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 1111/ Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 6 NOther (Spe 1 🔲 Inpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, AR/L HEIGHT

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib

Tracey A. Bower	rs, J		ate of Maryla								ibie.			
		l-For State Registrar		Cer	rtificate o	f Death					j. No. 2	OB	9 3446	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)								2. Date of Death Month Day Year October 25, 2009			3. Time of Death 0120 hrs	
Medicai Exaim		Tracey Bowers, Jr.  4a. Facility Name (if not institution, give street and number)  4b. City, To					vn, or Loc	or Location of Death  4c. County of Death						
Ž.		St. Agnes Hospital				Baltimo	re				N/	′ A		
Funeral	П	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	_		4Hrs. 8.1 Min.	Date of Birth	(MM/DD/YYY	Y) 9. Biri Foreig	thplace (State or	
Director		213-02-0163	27 Yrs. World's Days Rouls Will.					0	08/06/1982   Country) MD.					
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										_	10d. Inside City Limits	
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larylan 8a-f s	Director	10e. Street and Number 10f. Zip Code							10	g. Citizen of V	Vhat Cou	ntry?		
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15-C filed v of other								,	e (First, Middle, Maiden Surname)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To Be	Tracey A. Bowers, Sr. Janet  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru								Foger				
MD id 2 sho lith and n 27 is		Tracey A. Bo	owers, S	r.	357	Mary	del1	Roa	ad,B	altin	nore, N	ld.	21229	
re, f I and I Heals If item		20a. Method of Disposition  1 X Burial 2 Crematio	p 3 Pomoval fr	•	Place of Dispo crematory or o		of cemet	tery,	Da	te	20c. Location	n - City or	Town, State	
Pages Pages nent of ant: I		4 Denation 5 Other S											Mill, Md.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I file the fire than "marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Ī	22 Name and Address of Facility EStep Brothers Funeral Service Livense 1300 Eutaw Place, Baltimore,										rvic	e, PA	
		23e Part I. Enter the disease, o	r complications that	aused the death	n. Do not enter	the mode of	EUt 2 dying, su	tw P	Lace	, Ba_ piratory arre	Lt1mO1	ce, neart	Md. 21217  Approximate Interval	
Physician /Medical		failure. List only one cause on each line.  Between Onset and Death												
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
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68760 certificate t nding physi	lan/	23b. Was decedent pregnant in t past 12 months?	I Live	oirth nant at time of d	ooth Z	etal death	3	Ectopic p	regnancy		Month		Day Year	
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tal Recition: The certificate	Be (	25. Was case referred to medical examiner? 26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other:  Other: 1 Nursing Home 5 Residence 6 Other:												
of Vit ing Physic After this	٦	1 Ves 2 No 1 Inpatient 2 EK/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other:										ər: 		
Division of Vital Records, ra aber death or Attending Physician: The law requir and birector: After this certificate has been sited in by the funeral director, page 2 should be	tion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Oct 25, 2009 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No								Subject was shot				
ivisior or Attend after death Director:	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.							28f	28f. Location (Street and Number or Rural Route Number, City				
Dispital of ours at filled	Certification:	4 ✔ Homicide determined (Specify) Local Street							305	or Town, State) 3054 Bero Road , Baltimore, Md				
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Tunours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) mel we determined the time, date and place, and due to the cause(s)												
To 1 To 1	Medical	and manner stated.  29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)				
		O.C.M.E.								October 25, 2009				
3		30. Name and address of perso	•	,										
			puty Chief Medi			,	, Baltin	nore, M	ID 2120	1	<u>.</u>			
Si Regis	tate trar	31. Date filed (Month, Day, Year,	9000 32. R	gistrar's Signar	ture .	arked								
		nct 2	8 COOS /C	CHICAGO CONTRACTOR OF THE PARTY	1 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per inf g906 8-18-10 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:00 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 7920 Westmoreland Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 6. Sex **Funeral** Country) Maryland Days Hours Min 38 30-2304 1 M 2 - F **Director** 1944 Jul 23, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland at Director or 28a-f sl notified 1 Yes 2 ☐ No Parkville Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral USA 21234 7920 Westmoreland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. Black Specify. Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Red Cross** Driver/Delivery Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bernice Byrd William Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7920 Westmoreland Avenue Baltimore, Maryland 21234 Norma Bowman Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 🛙 🙀 Burial 2 🗌 Cremation 3 🗎 Removal from State Baltimore, Maryland 10/28/09 4 Donation 5 Other (Specify) Parkwood Cemetery Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final ₽πysician/ mon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signatures Completed 24b. Were autopsy findings available 24a, Was an s certificate has the director, page 2 s prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to hedical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗂 No 4 Nursing Home 5 Residence 6 Other (Specify ဂ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide M Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200

8

State Registr<u>ar</u> 30. Name and address of per-

31. Date filed (Month, Day, Year)

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 16a-b, 20a-c, 22 perFh, 898 12/7/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BLEVINS OCTOBER 15 **Physician** KOBERT 2009 /Medical 4a. Facility Name (If not institution, give street and number)
BON SECOURS HAS 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 20, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Funeral 1**∑** M 2□ F Hours Months Days 1949 Director 227-74-3303 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

• marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Evanting must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√2 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 511 S. Vincent Street 21223 USA Be Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 12 should be fi th and Mental I permit Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evance. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Andrea Greene/friend 1617 COle Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 X Other (5 3 Removal from State 11/6/2009 Mt. Carmel Dundalk, MD 22 Name and Address of Facility Wesley Chavis F.H., 200/ Eastern Ave State Anatomy Board 655 W. Baltimore Street 21. Signatur of Euneral Truice Licersee Ronal S Wate, Baltimore, MD 21201 21231 23a. Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca e (Final disease or con resulting in death) ARTERY CORONA RY Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine PULMONARY DISEASE the death certificate be executed physician and the burial-transit IMMUNODEFICIENCY VIPUS DISTASE Box 68760, Physician/Medical attending pl IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached fo P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? r this certificate had raid director, page 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 -NO Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 M.D. D0030355 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOX SECOURS HOSPITAL State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 October 1:20 AM M <u>Leah Beth</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Jan 27 1 Birthplace (State or Foreign Country) **Funeral** 1 - M 2 7 F Months Days Hours Min **Director** Yrs 219-62-0238 Maryland Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4719 Hazelwood Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, . Was Decedent Ever Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene.
27 is marked other than "r raumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 realtor properties Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Francis Ryan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Betty Anne Strunk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isaac Boltansky/son 5446 Tilted Stone Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Struice Licensee Ronald S. Wale State Anatomy Board 655 W. Baltimore Street D/rector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Immediate Sause (Final Widesmand metallatic break concer lung Physician disease or condition resulting in death) Medical Due to (or a consequence of) **Examiner** S uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 1 Yes 2 9 Unknown ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 4 Nursing Home 5 Residence 6 POther (Specify) 1 ☐ Yes 2 ₺ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 W Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🛫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29c. License number 29d. Date signed (Month, Day, Year) DO41476 10.18.2009

Registrar

State

RAYMOND W. WILION M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAUMOND LI WILLON M.D. 6565 N. CHARLES ST, #416, BALTIMORE, MD 21204

32. Registrar's Signature

		_ For	Pleas	se Type or Pri State of M			Indelible Inlepartment of		-		_egible.	
		State Registrar				(	Certificate of	Death		Reg. No.	2000	31.1.71
Physicia	n	1. Decedent's Nam	e (First, Middle	. 0	im i	Λ			2. Date of De Month	eathDay	Year	3. Time of Death
/Medic	al		NHC_	- 11	JOOL	A			ECT	26	2009	
Examine	er	Howard C	County (	, give street and number General Hosp	ital		Colu				County of Death	d
Funeral Director		5. Social Security N 139-01-9	736	6. Sex 7. A	ge (In yrs. I 91		Months Dave		8. Date of Bi (Month, D Nov 17	rth ay, Year) 191	9. Birth Cou New	place (State or Foreign intry) Jersey
and ww		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	v. Town o	r Location					10d. Inside City Limits
Maryl I-f sho	ţo	Maryland	Howar	-d			cott City					1 □Yes 2⁄Q No
or 28s	Sire C	10e. Street and Nur					10f. Zip Code			10g. Citiz	zen of What Cou	intry?
ath wi	ral	3724 Fol	ly Quar	ter Road				042			USA	
urs a	by Funeral Director	11. Marital Status  1 □ Never Marr  ▼□ Widowed		12. Was Decedent Armed Forces' 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:	10/	s. 11 16	13. Was Decedent of If Yes, specify Cu 1 □Yes 2 🕅 No		pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White, Specify: Wh	
nin 72 hou s. in "natura Medical E	Completed			's Education tt grade completed)  College (1-4or	5.1)	((	ecedent's Usual Occ Give kind of work don fe. DO NOT use retir	e during most of wor	king	16b. Kir	nd of Business/Ir	ndustry
d with giene er tha	<u>ا</u>	Elementary/Second	moary (0-12)	College (1-40)	O+)	N	lanager			PSE	2 & G	
be file tal Hy of oth	Be	17. Father's Name		Last)				18. Mother's Nan		e, Maiden S	Surname)	
d Mer marke	ဍ	John B		-i- (Time Driet)		405.0	A-Trans Addition (Otto		y Zupko	0.1	.T 01-11- 7	"- O-4-\
id 2 sl Ith an 27 is r traur		19a. Informant's N		Daughter		1	Mailing Address <i>(Stree</i> $24~ ext{Folly}$ Q					
s 1 ar of Hea item other		20a. Method of Dis	position		20b. P		isposition (Name of crematory or other pi		Date		cation - City or T	
Pages 1 nent of H ant: If iter ary or oth			☐ Cremation 5 ☐ Other (S)	3 ☐ Removal from State pecify)			crematory Crematory		27/09	Bal	timore.	Maryland
permit. Departr Importa any inju		21. Signature of Fu	ineral Service I	Licensee Thomas			22 Name and Add Crematio	ress of Facility n Society erick Road	Of Mary	yland	, Inc.	m.1 01000
		23a. Part 1. Enter t	the disease, or	complications that cause only one complete second and the complete second and	d the death	n. Do no	t enter the mode of d	ying, such as cardiac	or respiratory	arrest,	Maryla	Approximate
Physician		shock, or hea Immediate Cause disease or condition resulting in death)	(Final	-a. Dys	ine. Phili	2.0						Interval Between Onset and Death
/Medical Examiner	_			b. Due to 3 as	consequ	ence of)	10	val Ef	fusio	4		unknown
be executed cian and urial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death)	S	c. Pu	me	har	y Infi	Itrates				unknown
g cga	_			d. Und	erly	line	¿ lung	Mass				unknown
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the bearened.	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? □No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			2	23d. Date of deli Month	very Day Year
es the igne	à	Part II. Other signi	ficant condition	ns contributing to death I	h'a	ulting in th	ne underlying cause g	given in Part I.			se contrib <i>u</i> te to ☑No 3☐ Pro	the cause of death?
aw requir as been s 2 should	plete	Atr	ial F	ibrillation	n				24a. Was		24b. Were aut	topsy findings available
ician: The law certificate has b ector, page 2 sh	e Completed	25. Was case refer	ng LS	tive Hear	+ +	ail	ure	26. Place of Dea	1 □ Yes	ormed? 2 No	death?	ompletion of cause of
Physician: this certific al director,	o Be	examiner? 1 ☐ Yes 2 ☑		Hospital:	ent 2	ER/Outp	atient 3 DOA	ther:			G □Other (Spec	cify)
Attending Physician: or death. ector: After this certifical by the funeral director,	tion:	27. Manner of Deat  1 Natural  2 Accident	th 5 Pending investig		ay, Year)	28b. Tin Inju	ıry W		28d. Describe			
를 불 를	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	at he		me, farm	street, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Ru	ral Route Number,
the Hospital hin 24 hours a the Funeral npletely filled	edical C	29a. Certifier (Check only one)	1  CertifyIn 2  Medical	g Physician: To the best Examiner: On the basis and manner s	of examina	wledge, tion and/	death occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
To the vithing to the complete	Ž	29b. Signature and	title of certifier	11	MA			nse number		29d. Date	e signed (Month	
nx1,		30. Name and addr	ress of person	who completed cause of	death (Item	) n 23a) (Ty	(no Brint)	69517		0	1	7,2009
VV		Syed	Owa	is Hasar			755 (	edar L	ane	Col	umbia	,MD21044
Stat Registra		31. Date viled (Mon	th, Day, Year)	2009 Regist	rar's Signat	ture	have					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1	For State of Maryland		artment of Health a		giene Reg. No. <b>200</b>	34472
Physician /Medical	1. Decedent's Name (First, Middle, Last)	E	SWOTT	2. Date of Dea Month	Day Year	3. Time of Death
Examiner	4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital		4b. City, Town, or Location of Baltimore City		4c. County of Death	place /Ctota or Foreign
Director	5. Social Security Number  212−78−1020    6. Sex   1	Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birtl (Month, Day Nov 28	y, Year) Cour	place (State or Foreign htry) unk
ith the Maryland or 28a-f show e notified at Director	10a, State 10b, County 10c, City MD	Balti				10d. Inside City Limits 1  Yes 2 □ No
with the a or 28 be not	10e. Street and Number 1623 Hakesley Street		10f. Zip-Code 21205		10g. Citizen of What Cou USA	ntry?
urs after death v urs after death v ir, or items 23s xaminer must t by Funeral	11. Marital Status unk  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 □ No ulf Yes, Give	nk	Nas Decedent of Hispanic Ori f Yes, specify Cuban, Mexican	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ameri Black, White,	
in 72 hou in 72	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give	dent's Usual Occupation kind of work done during mos OO NOT use retired)	at of working unk	16b. Kind of Business/li	
yiana 212 unid be filed with Mental Hygiene. arked other that artic event, the M	unk 17. Father's Name (First, Middle, Last)		unk 18. Mothe	er's Name (First, Middle,	, Maiden Surname)	unk
2 should and Men is marke is marke aumatic of	19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	ng Address (Street and Numb	er or Rural Route Numbe	er, City or Town, State, Zi	o Code)
0 0	Johns Hopkins Hospital  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Side  4 Donation 5 Tobser (Specify) in state	lace of Dispo	N. Wolfe Stree sition (Name of natory or other place)	t Baltimore Date	MD 21287 20c. Location - City or T	own, State
permit. Pages Department of important: If it any or or once.	21. Signalur of Funeral Soluce Licensee Nonal of S. Waar Trector	St Be	Name and Address of Facilitate Anatomy B		Baltimore :	Street
Physician	23a. Part 1 Enter the disease, or complications that caused the death shock, or heart failure. List only one caus on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequ	. Do not ent	er the mode of dying, such as	cardiac or respiratory at	rrest,	Approximate Interval Between Onset and Death
xecuted and al-transit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
te be e ysician he burit	Due to (or as a consequence)	ence of):		· · · · · · · · · · · · · · · · · · ·		
the attendi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	v <b>ery</b> Day Year
aw requires that the seen signed by 2 should be deta	Part II. Other significant conditions contributing to death but not resu	ulting in the u	underlying cause given in Part	1. 23e. Did to	obacco use contribute to Yes 2 ☑ No 3 ☐ Pro	the cause of death?
				24a. Was a autop perfor 1 🗌 Yes		opsy findings available completion of cause of
vitali sician: 1 certificat lirector, p	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	Other:	of Death (Check only or	ne)  dence 6  Other (Speci	(fv)
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.  Medical Certification: To Be (	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Place of injury - At hor building, etc. (Specify)	28b. Time o Injury	f 28c. Injury at Work? M 1 \( \triangle \text{Yes}  2 \)	28d. Describe h	how injury occurred  Street and Number or Ru	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier (check only one)  Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinati and manner stated.	vledge, death		nd place, and due to the	cause(s) and manner as	
To the virthin To the comple	29b. Signature and title of certifier	·	29c. License number	726	29d. Date signed (Month	Day, Year)
	30. Name and address of person who completed cause of death (Item	23a) (Type,		600 North Wo	olfe St, Baltimo	re, MD, 21287
State Registrar	31. Date filed (Month, Day, Year)  OCT 2.8 2009	re pa			I.	

Registrar DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001

the

31. Date filed (Month, Day, Year) Registrar

29a, Certifier

29b. Signature and title of certifie

Medical

821 N. EUTAW ST Shile 308 BALTIMORE MD 21261 MD . HASHMI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31464

29d. Date signed (Month. Dav. Year)

10/2-3/05

		1 - State Registrar  1. Decedent's Name (First, Middle, La.	State of Mary	•	rtificate of			leg. No2	109	3 4 4 3. Time of I	7 4 Death
Physicia /Medio		ANNETTE	RENA		BRANDT		OCTOBER		2009		РМ
Examin		4a. Facility Name (If not institution, giv EDENWALD NURS				or Location of Death			nty of Death LTIMOR	Ε	
Funeral Director		5. Social Security Number 6. S 578-30-5841	ex 7. Age (In 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 06/18/1	928		olace (State or SHINGT)	
death with the Maryland ms 23a or 28a-f show r must be notified at	tor	Usual Residence of Decedent  10a. State  MD  BALTIM		. City, Town or Lo	TOWSON				1	0d. Inside Cit	,
with the 3a or 28s	Il Director	10e. Street and Number 800 SOUTHERLY R	OAD, #813		10f. Zip Code 212	86	1	10g. Citizen o	of What Cour	ntry?	
5-UU36 72 hours after death with the Marylan retural", or items 23a or 28a-f show dital Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 从 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 □Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. R B	Race - Americ Black, White, o		
Z1Z15-U	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed)  College (1-4or 5+)	(Give	DO NOT use retire	during most of work	king		Business/Ind	,	
/land	To Be C	17. Father's Name (First, Middle, Last, NATHAN		HAPIRO		18. Mother's Nam	•	Maiden Surn	·	RSTONE	
nd 2 sho alth and 27 is me		19a. Informant's Name/Relationship (FREDERICK B. BRA				t and Number or Ru		•			
altImore, nit. Pages 1 an artment of Heal ortant; If item 2 Injury or other		20a. Method of Disposition 1 IX Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Db. Place of Dispo cemetery cree BETH EL	osition (Name of matory or other pla MEMORIAL	PARK 10/	Date 25/2009	20c. Locatio	n - City or To DALLST	own, State	D
Dalti permit. Departm Importa any Inju		21. Signature of Funeral Service Vicer	attle	23		ess of Facility SO ISTERSTOW					208
by Court tilicate be executed / Medical Examiner and as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a cor  Due to (or as a cor  Due to (or as a cor  Due to (or as a cor	requence of):	les to		nentr		liune	Approximate interval Bety Onser and C	ween
the death certification of the attending of the attending of the attending of the attending of the as as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of pr 1  Live birth 2 4  Pregnant at time 9  Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су			Date of delive	,	⁄ear
DIVISION OF VITAL RECORDS, P. O. BOX To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. The the state of th	Completed by Phys	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause gi	ven in Part I.	1 □ Y	es 2 No	3 ☐ Prol	opsy findings a	Jnknown available
VICAL ME Ician: The la certificate ha ector, page 2		Of Was asses referred to medical						med? 2 <b>124</b> 6	prior to co death? 1 ☐ Yes	empletion of ca	ause of
T VIII  ysicia ysicia is certi directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Oti		th <i>(Check only or</i> ome 5 ☐ Resid		Other (Speci	 fy)	
on or ding Phy th. : After this funeral d	tion: T	27. Man of Death 1. A Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea	28b. Time o Injury	Wo		28d. Describe h				
DIVISION OT VITA To the Hospital or Attending Physician: Whith 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (S)	pecify)			28f. Location (S City or Tow	n, State)			ber,
n 24 hou n 24 hou ne Funer	Medical	29a. Certifier (Check only one) (Check only one)	nysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, deat mination and/or in	th occurred at the to extigation, in my	time, date and place opinion, death occu	e, and due to the d rred at the time, d	cause(s) and date and plac	manner as see, and due t	stated. o the cause(s	)
To the within To the Complex C	Me	29b. Signature and title of certifier  30. Name and address of person who	completed cause of death	tem 23a) (Type,	29c. Licen	se number 2 9 7 6	9 1	29d. Date sig	ned (Month,	Day, Year)	778
Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	an o	(6,0,1)	w/him	13/	2000	, un	
Registr DHMH 17 Rev 1/2		OCT 27 200	J Chowa	B. ga	Kol						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

**OCME** 

**ORIGINAL** 

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d, Date signed (Month, Day, Year)

October 25, 2009

and manner stated

addr ss of person who completed cause of death (Item 23a)

MARY G. MPBLEIM

Registrar's Signatu

Assistant Medical Examiner

and title of pertil

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

29b. Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 per MD 8896 10/29/09 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month reimarine 23-2009 /Medical Del-Marine A. Coles 4a. Facility Name (If not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Sheldon 6. Sex If Under 24 Hrs. Hours Min. Date of Birth (Month, Day 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 Year Days 1 □ M 2 X F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Injury or other traumatic event, the Medical Examiner must be notified at Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No Specify Specify: Klack 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) Coles ပ္ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Luther 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee MOI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause un each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify). Day Year detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, the signed by has been after death.

Director: After this certificate completely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral E

Baltimore, Maryland 21215-0036

State Registrar

(Check only 296. Signature and title

31. Date filed (Month, Day,

30. Name and address of person who com

ST. PAUL

Tea/)

cause of death (Item 23a) (Type, Print)

ACE BALT?

29d. Date signed (Month, Day, Year)

2009

10/27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Valree Carter 200 /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Courtland Garden Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M & F So. Carolina Director 216-20-0802 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State or 28a-f ehow il Hygiene. other than "natural", or items 23a or 28a-f ehow vent, the Medical Esartheth aust be notified at 1X Yes 2 No Baltimore **Baltimore** Director Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 5604 Haddon Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Completed by 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) or other traumetic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked ofth any injury or other traumetic event gotes. 17. Father's Name (First, Middle, Last) Be Janie Williams James Walker ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 Burningbush Court Stafford, Virginia 22554 Leon Carter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/09 Laurel, Maryland Maryland National Park Cemetery 4 🗆 Dop 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Serv e Licenset Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final 6 Ma **Physician** disease or condition resulting in death) /Medical Due or as a consequence of): Examiner Sequentially list conditions, I any Leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months? ŏ 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 2□ No 211 No 1 Tyes Division of Vital To the Hospital or Attending Physicien: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient Other: 4 Jursing Home 5 TResidence 6 Other (Specify) 20 1 🗌 Yes 2 ER/Outpatient 3□ DOA 2 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After Injury 1 F Natural 5 Pending 1 Tyes 2 🗌 No investigation death, 2 Accident Director: in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Retriebere alle Registrar's Sign State Registrar

2009 34478

		1- For State Registrar	Certificate	of Death		Reg	J. No.	0
Physicia		Decedent's Name (First, Middle,Last)	_			Date of Death     Month	Day Year	3. Time of Death
ledical Exami		Shaneece Crawford				October 17	, 2009	1930 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of	Death	4c. County of Death	
		2802 Bookert Drive		Baltimore	Trees to-	Odline IO Date of Birth	N (MM/DD/YYYY) 9. Bir	/A
Funeral Director			n yrs. last birthda	y) If Under 1 Yea Months   Day		Min.	Forei	gn
Director		215-17-9792 1 M 2XF	29	Yrs.		10/16	/1980	ountry) Md.
<b>≥</b>	ŀ	Usual Residence of Decedent  10a, State 10b, County 10	c. City, Town or L	ocation				10d. Inside City Limits
ow any		,						1 X Yes 2 No
Maryland 28a-f show 1 at once.	ġ.	Md. N/A	Ват	timore			g. Citizen of What Cou	intry?
Mar.	Director				_			,
ith the		2802 Bookert Drive  11. Manital Status 12. Was Decedent Ev	or in II.S. 115	2122		n? ( Specify Yes or No-	USA	rican Indian, Black,
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	uneral	1 X Never Married 2 Married Armed Forces?		If Yes, specify Cubar			White, etc.	
er de	щ	1 Yes 2 X	No	1 Yes 2 Y No	specify:		Specify: R1	ack
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	<u>S</u>	15. Decedent's Education (Specify only highest grade complete		cedent's Usual Occupa	tion (Give ki		16b. Kind of Business.	
72 hou	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	duri	ng most of working life	e, DO NOT u	ise retired)		
036 thin 7, ne.	ğ	12	Se	curity G	uard		Securit	у
5-0036 iled within 72 Hygiene. J other than	ပ	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle, M	laiden Surname)	
21215-003 uld be filed withi Mental Hygiene. marked other ti	Be	Theodore Crawford					a <u>wford</u>	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relationship (Type, Print )				per or Rural Route Num		
MD nd 2 sho alth and m 27 is		Maxine Crawford  20a. Method of Disposition		U2 BOOKE:		ive,Balt:	1.MOTE, Ma.	
ore, of He of He	Ш	1 X Burial 2 Cremation 3 Removal from State	crematory	or other place)			,	
Page Page ment or of		4 Donation 5 Other Specify:				10/23/09		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minury or other traumatic.		21. Sign uneral Service Licensee	)	22 Name and Address	rothe	ers Funera Place,Bal	al Servic	e, PA
		23a. Part I. Epper the disease, or complications that caused the	death. Do not e	nter the mode of dving	. such as ca	rdiac or respiratory arre	timore, IV.	Id. 21217 Approximate Interval
Physician /Medical		failure fast only one cause on each line.			,	,		Between Onset and Death
' cantiner		Immediate Cause (Final disease or condition resulting in death)  a. Seizure di  Due to (or as a consequ						
		Sequentially list conditions, b						
x	e e	if any, leading to immediate cause. Enter Underlying Cause	uence of):					
Je	Examine	(Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseq	uence of):					-
executed an and al - transit		d.	•					
an g	/Medical	XUNPENDED AMENDED 232	27 parM	E, g897 11	/16/09	) TrT		
760, ficate be ex g physician t the burial	8	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of delive	ry
15. 00		23b. Was decedent pregnant in the past 12 months?	( ) -0	Fetal death 3	Ectopic	pregnancy	Month	Day Year
Box 687 he death certifi the attending	Sic	1  Yes 2 No 9  Unknown g Unknown	ne of death 5	Other (Specify)			1	
	Physician	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause	given in Pa	rt I. 23e. Did to	bacco use contribute t	o the cause of death?
res that the signed by	þ						2 🗸 No 3 🗌 Pr	obably 4 Unknown
ords, w require is been si should b	ţe					24a. Was		autopsy findings available
COF law r has b	Completed						rmed? death?	
	Ŝ	OF Management to another the		26 Plac	e of Death (	1 Yes Check only one)	2 No 1 🗸	Yes 2 No
ital lician: s certifi rector,	മ	25. Was case referred to medical examiner?  Hospital: 1 Inpatient	2 FR/Qutn	atient 3 DOA	1 Othor		Residence 6 🗸 Oth	er: Scene
of Vital Records, ing Physician: The law requir After this certificate has been s' uneral director, page 2 should b	P	1 V Yes 2 No 28a. Date of Injury (Month, Day,Yea			ury at Work		how injury occurred	
ion of tending Pheath.	o	1 X Natural 5 Pending (Month, Day, Yea	r)	1	Yes 2	No		
	icat	2 Accident Investigation 28e. Place of Injur	ry - At home, farm	n, street, factory, office	building, etc	c. 28f. Location (	Street and Number or F	Rural Route Number, City
Divisipital or At ours after diffeed in by	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, S	State)	
Hosp 24 hou Fune rely fi		29a. Certifier 1 Certifying Physician: To the best of my	nowledge, death	occurred at the time,	date and pla	ice, and due to the caus	se(s) and manner as st	ated.
Divisi  To the Hospital or At within 24 hours after d  To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or inve	estigation, in my opinio	n, death oc	curred at the time, date	and place, and due to	the cause(s)
E 3 E 8	Me	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (M	• •
		Man Brandl. M.	7	0.0	.M.E.		October 18, 20	09
1, 9		30. Name and ddress of person who complet d ause of dea		1			•	
Oxpend		Melissa Brassell, MD Assistant Medical E	y	11 Penn Street,	Baltimore	e, MD 21201		
3	late	AAT A O 71819   //2	Signature	parker				
Regis	urali	UU 20 /	1 1/1/	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #3 per MD g896 10/28/09 TT

State of Maryland / Department of Health and Mental Hygiene 34479 Certificate of Death Reg. No. 2 [] 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year James Thomas Cavey October 22, 2009 11:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102G Nichols Street Bel Air Harford County 8. Date of Birth (Month, Day, Year)
March 30,1925
Baltimore, M. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₺ M 2 □ F Months Days Hours Min 84 217-20-3546 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Weden Event in the Indian once. 10a. State 10h. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford County Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102G Nichols Street 21015 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Nes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced W.W.II Year or Dates: Completed Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Banking Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Wilton Cavey Grace Elizabeth Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Alta Lois (nee Koch) Cavey 102G Nichols Street Bel Air, Maryland 21015 Oct. 27, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest V.A. 2009 Owings Mills, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
22.25 York Pope Timonium, Maryland 21093 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heartifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPLATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNG DISCASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 TYPS 2 No. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □Yes 2 2No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200° 10025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Physician: The law requires that the death certificate be executed

or Attending

Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

6 31. Date filed (Month, Day,

98

parks

32. Registrar's Signature

Breun

PLLONA

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	nd / Depa			d Mental Hy	giene Reg. No. 2009	34480
A.	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Josephine R. Con     Aa. Facility Name (If not institution, give s			4b. City, Town, G	or Location of De	2. Date of Dea Month Octobe	D	19 3:25 PM
mark of	Funeral Director		5. Social Security Number 6. Sex 224–32–8943	2.00 F 7. Age (In yrs 87	. last birthday) Yrs.	Princes If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Birt	y, Year) C	set rthplace (State or Foreign ountry) rginia
	the Maryland 28a-f show	rector	Usual Residence of Decedent		ity, Town or Lo				10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2√ No
36	should be filed within 72 hours after death with the Maryland Ind Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show umatic event, it s. Mc. deal Exercite count to recitified	by Funeral Director	302 Market Stree	L 2. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 No If Yes, Give				(Specify Yes or No- erto Rican, etc.)	USA - 14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036	within 72 hours iene. 'than "natural";	Completed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  12	Year or Dates:	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire homemake	pation during most of v d)	vorking	16b. Kind of Business	
Iryland 2	should be filed nd Mental Hyg marked other imatic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Joseph M. Roane  19a. Informant's Name/Relationship (Ty)		19b. Maili		18. Mother's N	lame (First, Middle,  nia Baker  Bural Boute Number		Zip Code)
re, Ma	is 1 and 2 of Health a item 27 is other tra		Joe Condy1es/spou  20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	se 20b. emoval from State	106 Place of Dispo		lace Poo	comoke, MI	-	
Bail	permit. Page Department of Important: If any injury or once.		21. Signature 17 no al Sirco License ROII 20 L	ations that caused the dea	r Si	altimore,	omy Boa MD 21	201	Baltimore rrest,	Street  Approximate Interval Between
	Physician /Medical Examiner	ical Examiner	Immediate Sause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec	quence of):	<i>D</i>				Onset and Death
O. Box 68/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1	aldeath 3[	∃Ectopic pregnand Gother (specify)	су		23d. Date of do	elivery Day Year
Records, P.	w requires that t s been signed by should be detac		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.		obacco use contribute Yes 2 □ No 3 □ F	to the cause of death? Probably 4 Unknown
Ital Rec	ician: The law i certificate has b rector, page 2 sh	Be Completed	25. Was case referred to medical				26. Place of D	24a. Was autop perfo 1 □ Yes	prior to death? 2 ☐ No 1 ☐ Ye	autopsy findings available completion of cause of s 2 \sumbed No
Division of Vital	ending Physici ath. r; After this ce te funeral direc	Certification: To B	examiner?  1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	ry at		dence 6 ☐ Other (Sp how injury occurred	ecify)
DIVIS	e Hospital or Attend 124 hours after death e Funeral Director: , letely filled in by the f		3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci ician: To the best of my kn	ify)		ime, date and pl	City or To'v		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Chack only one) 2 Medical Examination Medical	ner: On the basis of examin and manner stated.	ation and/or in	29c. Licen	opinion, death o	ccurred at the time,	date and place, and du 29d. Date signed (Mor	nth, Day, Year)
	Sta Registr		30. Name and address of person who co Vel Natesan MD 31. Date filed (Month, Day, Year) DCT 2 8 200		sion .		oteB S	alisbury,	MD 216	704

Issephine Condyles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ elen 3: 50 AM 2009 Medical 4a. Facility Name (if not institution, give street and nu Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Health Center Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 A Months Hours Min. (Month, Day, Year) Pennsylvania Director 142-16-6169 Mar Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Funeral Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR219 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event: the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 switchboard operator Bell Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Glova Bessie Belitza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Carpenter/daughter 118 Robert E. Lee Lane Bluffton, SC 29909 in 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 K Donation 5 Tother (Specify) permit. Signature of Euneral Servi 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 6 Baltimore, MDPart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examiner Due to lor as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year Month Day Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? after death.

Director: After this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 3 29d. Date signed (Month. Day, Year) 10

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who

Date filed (Month, Day, Year)

28

Cane

Catonsville

21228

empleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

hoice

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within 24 hours after death Fo the Funeral Director:

29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 14 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14812 CN #16 ( 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 Dorothy Clough- Waltz October 11:500Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kerr Road Whiteford Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Ye Days Country)
Maryland 1 □ M 2 🖫 F Hours Director 218-36-0754 Nov Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Whiteford Maryland Harford 10e. Street and Number 10g. Citizen of What Country? Funeral <u>United</u> States 1572 Kerr Road 21160 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin. Elementary/Seconday (0-12) 12 Own Home Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Leroy Clough Marie Allum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Waltz/ Husband 1572 Kerr Road, Whiteford, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 26. 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 letro Crematory. Baltimore, Maryland Inc 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society Of Maryland, Inc. Challetop 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final BREAST Physician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

Registrar

21215-0036

Box 68760

P.O. |

Records,

**Division of Vital** 

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

DERNANDO 31. Date filed (Month, Day, Year)

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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October 26, 2009

		1- For State Registrar	State of Marylan		artment of Heal			ne No.2009	34484
Physic		1. Decedent's Name (First, Middle, Last	)	0	Licaroni		2. Date of Death		3. Time of Death
Physic Medi	cal	EDDIE  4a. Facility Name (If not institution, give	etreet and number)		THE CITY, TOWN, or LOCA		october	4c. County of Death	17:17 M
Exami	ner	The Johns Hopkins Ho			Baltimore Ci			To South of Double	
Funeral	Г	Social Security Number     6. Se	x 7. Age (In yrs.		If Under 1 Year If U	Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	ar) Count	
Director		215-60-1233	56	Yrs.			Jan. 27	,1953 ME	)
ryland ihow		10a. State 10b. County		ty, Town or Lo				1	10d. Inside City Limits
ne Mau 28a-f s otified	Director	MD	Ва.	ltimon			100	Citizen of What Coun	1 XYes 2 No
If yield ( Z   Z   3-0030 thould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	I Dir	10e. Street and Number 601 N. Decker A	ve.		10f. Zip-Code 21205		0	JSA	tr <b>y</b> ?
ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, Mo	nic Origin? (Sper lexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
rs after	by Ft	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No Sp	pecify:		Specify: Bla	ick
2-UCSO 72 hours aft natural", or lical Examin	ted	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupation kind of work done during	n ng most of workir	16	b. Kind of Business/In-	dustry
vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	DO NOT use retired)			altimore	Cty
Filled v Hygie Other t	Be Co	17. Father's Name (First, Middle, Last)	•		18.		e (First, Middle, Ma		
aryicand Z 1Z should be filed with nd Mental Hygiene. marked other than umatic event, the M	To B	James Brown				lara Ca			
8 s a s		19a. Informant's Name/Relationship (T) Nicole Cannon	rpe. Print)		ng Address (Street and i				
of Health of Health fitem 27		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	osition (Name of matory or other place)	1		c. Location - City or To	
Salumor permit. Pages Department of i mportant: If ite iny injury or o once.		4 Donation 5 ☐ Other (Specify	MIT	-	nel Cem.  2. Name and Address of	10/23		undalk,MI	
Dall permit. Departit Importa any inju		21. Signature of Funeral Service Licens	Mark		007 Easter				
		23a, Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that dused the deat ne cause of each line.	th. Do not en	ter the mode of dying, su	uch as cardiac c	or respiratory arrest	1	Approximate Interval Between
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/Medical Examiner	ı	resulting in deatry	Due to (or as a consec	quence of):					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consec	quence of):					
X DS/DU, certificate be executed ding physician and use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
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the degree of the all	hysic	1  Yes 2 No 9 Unknown	9 Unknown	deam 5					2=-
requires that the death certificate signed by the attending should be detached for use a	by P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	underlying cause given i	in Part I.		cco use contribute to t	
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has b	Completed						autopsy performe	prior to co	ompletion of cause of
VITAL siclan: Th certificate irector, pa	Be C	25. Was case referred to medical			. 26	. Place of Death	(Check only one)	FINO 1 TES	2 10
OT VITA Physician: rthis certific eral director,	일	examiner? 1  Yes 2	Hospital: 1 Impatient 2	ER/Outpatie	nt 3 DOA Other: 4	4 - Nursing Hor	me 5 Residence	ce 6 🗆 Other (Specif	ÿ)
ION OT VITAL  rding Physician: \[ \text{ith} \]  th. \[ \text{: After this certifical} \]  e funeral director, F		27. Manner of Death  1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	2   No	28d. Describe how	injury occurred	
OIVISION or Attending after death. Director: After in by the fune	ificat	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined				_	28f. Location (Stre City or Town, S	et and Number or Rur	al Route Number,
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	4   Hornicide	0		th occurred at the time	date and class			etated
e Hosp 24 hou • Funel letely fi	edical		ysician: To the best of my kno niner: On the basis of examin and manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier			29c. License nur			l. Date signed (Month,	Day, Year)
		Man Kan	eme		RESC	000	U	itober .	14, 2004
		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	, Print)	1 000	North Wolfe	St, Baltimo	re, MD, 21287
S	tate	31. Date filed (Month, Day, Year)	32. Registrar' Sign	atue	1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 34485 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year AY. Tev 0840 AM 2009 20 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death amar If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min 77 215-28-1847 Feb. 28,1932 Mississippi Usual Residence of Decedent 10b. County 10c City Town or Location 10d. Inside City Limits Y⊟Yes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2411 Hermosa Ave. 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer Bethlehem Steel Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Carter, Sr. Mary Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia E. Carter (wife) 2411 Hermosa Ave. Balto, Md. 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Pk. Nov, 2, 2009 Baltimore, Md. 1. Sun ture of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home  $_{\rm E}$ Preston St. Balto, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final etastati disease or condition resulting in death) yours Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24540 2 □No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

**Funeral** 

**Director** 

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Tre Medical Exeminar in ust be in villad at

n and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othe any lighty or other traumatic event once.

filed within 72 hours after

3altimore, Maryland 21215-0036

P.O. Box 68760

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Hospital or Attending Physician: The law requires that the death certificate

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neral Director; , y filled in by the f

death.

To the Hospital within 24 hours a To the Funeral C completely filled

Division of Vital Records,

Examiner burial-transi attending physician a signed by the a d be detached for þ Completed

Physician/Medical Be မ

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 □ DOA 28b. Time of

28c. Injury at Work? 1 □Yes 2 □No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Baltimore, MD 21239

3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Charles Detaoth

5 Pending investigation

29c. License number D15546

Blud

29d. Date signed (Month, Day, Year) ,27,2009

State Registrar

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curries Padgett ND 31. Date filed (Month, Day,

32. Registrar's Signature

5601 Lock Raven

Amend 28a Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. & f per ME 8897 11/10/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MATTHEW Year CHERRY Seco /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death Examiner HE LINThlews TERO 307 m If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 08/01/19/1 9. Birthplace (State or Foreign Gountry) MD **Funeral** 38 Months Days Hours Min 1 X M 2 □ F 220-68-1632 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County ital Hygiene. Indoper then "natural", or items 23a or 28a-f shov event, the Medical Experient must be confibed at Director 1 ☐ Yes 2 X No MD BALTIMORE LUTHERVILLE filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? COOL SPRING COURT 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Completed by Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES FLOORING ges 1 and 2 should be filed wi nt of Health and Mental Hygier If item 27 Is marked other th or other traumatic event, Its 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **AARON** CHERRY **JACOUELINE** ZUCKER 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 any injury or other tr JACQUELINE BERNSTEIN/MOTHER <u>10 E. LEE STREET,#1807, BALTIMORE, MD 21202</u> Baltimore, 20b. Place of Disposition (Name of certain SHETTAIN CEMETERY 10/25/2009 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or at Examiner TANGINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in ilitated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 🔲 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending Injury UNKM 09 2 Accident investigation 1 ☐ Yes 2 No after death Director: the 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and North of Rero Dr Apt 307 filled in by determined To the Hospital or within 24 hours at To the Funeral D -00 M 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier Sput 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Nes in Registrar's Signature 31. Date filed (Month, Day, Year) State 32. OCT 27 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARAH DICK ENS 10:50 A M OCTOBER 22 2009 Medical 4a. Facility Name (if not institution, give street and number) 3410 Tulsa Rd 4b. City, Town, or Location of Death Examiner 4c. County of Death Ballimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MA 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗗 F Days 86 Director rral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director MDimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1120 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", 3 ₩idowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည orence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fna irrore 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of Important: If it ō 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Baltimore, 11-3-2009 4 Donation 5 Other (Specify) Signature of Funeral Service License Randall stown, MDZ1133 23a. Part 1. Enter the dise ase, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, e. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph\_sician/ ANCEL TO THE LUNGS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Dav Year signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown I Director: After this certificate has been d in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ျှ 1 ☐ Yes 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred ✓ Natural 5 Pending 2 Accident
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier R088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATHUSSN C. STAMMY 25 MAIN ST

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

RSISTRISTOUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TOBER 1257 M Paul Austin Dyer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL EASTON HOSPITAL ALBO Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 <del>X</del> M 2 □ F Days Hours Min Aug 17 Pay, Yang 31 Massachusetts **Director** 0002-22-4668 78 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Talbot 1 🗋 Yes 2 🔀 No MD Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 640 Mecklenburg Avenue #304 21601 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Ares 2 No Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No Specify Il Hygiene. other than "natural", 152-54 Specify: white Completed 3 Widowed 4 Divorced Year or Dates Maryland 21215-0 unl 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) antiques dealer Be permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Henry Dyer Emma Martha Michaels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 640 Mecklenburg Avenue #304 Easton, MD 21601 Faye Dyer/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Signature of a neral arvice Licensee Kon Td S Waz State and Addresmy action of 655 W. Baltimore Street rector 21201 Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shock Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events ng physician and as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🌠 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No Yes 2 No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 K No မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 Yes 2 No Investigation

the Hospital or Attending Physician: The law requires filled in by the funeral 24 hours after deat Funeral Director:

. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place and one to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number,

0

W22

State Registrar

Medical

6 Could not be

32. Registrar's Signature

within 2 To the I

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G896, 10/28/09, WS

State of Maryland / Department of Health and Mental Hygiene 34489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Dauner 2:58 A M Nicholas October 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Hospital Baltumore Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 2/10/1981 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 160-72-6797 28 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nothered. 28a-f show MD Prince Georges Laurel XXIYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7960 Ashford Boulevard 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Na 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Navy Black, White, etc. Yes 2 □ No If Yes, Give Year or Dates: 1₺ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 03 - 08Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer US Government 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeff Dauner Debra Naehring ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Dauner / Father 2968 Audubon Drive, Cincinnati, OH 45011 20a. Method of Disposition
1 □ Burlal 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Ardent Crematory 10/24/2009 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home., Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Euneral Service Licensee Victor Doda, Jr.  $\mathcal{M}$ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Demyelinating disease disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by icate has been si r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death. e Funeral Director: A letely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES000 2009

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland

John Hopkins Hospital

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

Katherine

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-go.,		1- For State Registrar	Certifi	icate of Deat			1. No. 28	19 3449
Physici	an/	Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3. Time of Death
edical Exami	ner	or cacr	L.		niels own, or Location of Dea	October 15	, 2009 4c. County of Death	2145 hrs
		4a. Facility Name (if not institution, give street 1223 Lafayette Avenue	and number)	Baltin		4(1)	46. County of Death	'
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last t	birthday) If Unde	er 1 Year If Under 24H	rs. 8. Date of Birth		thplace (State or Foreign
Director		216-34-0850 1XM 2	F 72	Yrs. Month	s Days Hours M	o5 19		untry) M.D
		Usual Residence of Decedent						
w any		10a. State 10b. County		wn or Location				10d. Inside City Limits
Maryland 28a-f show any d at once	tor	MD NA		Baltimor		140	033	1 XYes 2 No
e Mar or 28a	Director	10e. Street and Number 1223 West Lafayet	-+0 N 170	10f. Zip	21217	100	g. Citizen of What Cou <b>U • S • A</b>	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland (eath and Mental Hygiene the Carter and Mental Hygiene them 27 is marked other than "matural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at once.			as Decedent Ever in U.S.	13. Was Decede	ent of Hispanic Origin? (	Specify Yes or No-		ican Indian, Black,
leath v item	Funeral	1 X Never Married 2 Married A	rmed Forces? Yes 2 No		fy Cuban, Mexican, Pue		White, etc.	,
after c	by F	3 Widowed 4 Divorced If Yes, or Date	Give Year		XNo specify:		Specify:	lack
hours natur Exami		15. Decedent's Education (Specify only high			Occupation (Give kind or rking life. DO NOT use r		16b. Kind of Business/	Industry
36 iin 72 ihan "	plet		ollege (1-4 or 5+)	Superv	isor		State of	Maryland
d with	Completed	17. Father's Name (First, Middle, Last)	725			me (First, Middle, M		
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (	David Daniels			Thelm	a Clayto	on	
21 hould nd Me is ma	P	19a. Informant's Name/Relationship (Type, Pr			(Street and Number of			
ME 2 sauth an 27 raums		Penelope Prince-S  20a. Method of Disposition		LZ19 WeS	t Lafayet	Date	20c. Location - City or	
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.			noval from State cren	natory or other place	)		,	
fin Pagrithment Pa		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee /		Cedar Hi		/23/09	Baltimor	e, Ma
Ba Derm Depa Impe		Claring A DV	mpano	March	Address of Facility F/H West Wabash Av	e. Balt	imore. Mo	21215
Physician		23a. Part I. Enter the disease, or complication failule. List only one cause on each line		not enter the mode	of dying, such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a Hype	rtensive Atherosclero	otic Cardiovascu	ılar Disease			Death
,			(or as a consequence of):					
	je.		(or as a consequence of):					
10	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):					
Tansit and the control		events resulting in death) Last Due to d.	(or as a sombodacines or).					
760, Gate be executed physician and the burial - transit	Medical	UNPENDED AME	NDED					
760, icate be physical the burn	-	23h Was decedent pregnant in the	If yes, outcome of pregnan				23d. Date of deliver	
Box 68's death certification attending	sician	past 12 months?	Live birth Pregnant at time of death	2 Fetal death 5 Other (Spe	3 Ectopic pre	gnancy	Month	Day Year
Boy e death the att	Physi	1 Yes 2 No 9 Unknown g	Unknown	o Other topo				
bat the ed by letach	by P		outing to death but not resul	Iting in the underlying	g cause given in Part I.		pacco use contribute to	
S, P		Chronic alcohol abuse						bably 4  Unknown
ord aw rec as bee	Completed					24a. Was a autops	sy prior to	utopsy findings available completion of cause of
Rec The I ficate I	Con					1 ✓ Yes 2	2 No 1 V	es 2 No
ital ician: s certif	å	25. Was case referred to medical examiner?	1 Inpatient 2 ER		26.Place of Death (Che		Residence 6 🗸 Othe	w C
of V g Phys ter thi	٢.	1 ✓ Yes 2 No	T Inpatient 2 En		28c. Injury at Work?		ow injury occurred	r. Scene
Division of Vital Records, P.O and or Attending Physician: The law requires that it after death.  al Director: After this certificate has been signed be led in by the funeral director, page 2 should be detaed	Certification:	Natural 5 Pending	(Month, Day,Year)		1 Yes 2 No			
VISI or Att fter de Directe in by t	ifica	2 Accident Investigation 3 Suicide 6 Could not be	se. Place of Injury - At home	e, farm, street, factory	, office building, etc.			ural Route Number, City
Di pital ours a filled	Sert	4 Homicide determined (S	Specify)		-	or Town, St	ate)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a. Certifier (Check only one)  2 Medical Examiner: On the	the best of my knowledge,					
To tl withi To tl	Medical	2 and m  29b. Signature and title of certifier	anner stated.		c. License number	at the time, date a	29d. Date signed (Mo	
	-	(61111	A	23	O.C.M.E.		October 22, 200	
		30. Name and address of person who complet	ed cause of death (Item 23)	a)				
8	3	•	•		et, Baltimore, MD	21201		
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Mal			-	
Regist	ırar	OCT 28 2009 Ben	M. 10. 150	C-0-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1 helma 10 2009 /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Baltimore Johns Hopkins Barview Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Jan 27 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Year) 918 Days 214-20-6505 Months Hours Min. 1 ☐ M 2 🖫 F 91 Yrs. **Director** MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov MD Baltimore Director 1 Yes 2 No 10f. Zip Code 21206 10e. Street and Number 10g. Citizen of What Country? 5009 Frankford Avenue USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 □Yes 🏋 No Specify Black þ Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health a Theresa Diggs 1506 Division St. Baltimore, MD 21217 other i Baltimore, if item ? or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Ardent Crem. 10/20/09 Hanover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wesley Chavis, JR Fh 2007 Eastern Ave. Baltimore, MD 21231 23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final e, or complications that ca List only one cause on ea ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Priemonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) as the burial-Division of Vital Records, P.O. Box 68760. physician Completed by Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabete pertension. 1 □ Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate 2 No 1 □Yes 2 1 □ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier and manner stated. within 2 29b. Signature and the of certifier 29c. License number RE5-000

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

3715 FAIT AVE Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Jordan Piluek 3715 Fair Ave I

32. Registrar's Signatur

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ı		epartment of Health and M Certificate of Death	lental Hyg ห	giene leg. No 2009	34492
1	Physic /Medi		Decedent's Name (First, Middle, Last)     Archie P. Edwards		2. Date of Dear Month	th Day Year 23 2009	3. Time of Death
	Examine Funeral Director		4a. Facility Name (If not institution, give street and number)  Franklin Square, Hospital  5. Social Security Number  6. Sex 7. Age (In yrs. last birth  218 36 0005  1 \( \text{Q} \text{ M 2 \square} \) F 67	4b. City, Town, or Location of Death  Rose de le  If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day November	4c. County of Death  Baltim	
	ט	ior	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  Maryland Baltimore Essex	or Location			0d. Inside City Limits 1 □ Yes 2√□ No
	with the figa or 28a	al Dìrec	10e. Street and Number 501 N Marlyn Avenue	10f. Zip Code 21221	1	l 0g. Citizen of What Cour	ntry?
0036.T	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventival number to notified at once.	Completed by Funeral Directo	11. Marital Status  1 Never Married 2X Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1959~1962	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes		14. Race - Americ Black, White, Specify: Who	etc.
Archi d 21215	filed within 72 I Hygiene. other than "na ent, Inc Medic	Be Complete	(Specify only highest grade completed) (	Give kind of work done during most of worki life. DO NOT use retired)	ng	Mechanical Cor	
ds arylán	should be and Menta is marked aumatic ev	To B		Virginia M	al Route Number		Code)
$Ed\mathcal{Wards}$ $A$ Baltimore, Maryland	Pages 1 and 2 ent of Health nt: If item 27 I ry or other tra		20a, Method of Disposition 20b, Place of I	Disposition (Name of Corematory or other place)		and 21221 20c. Location - City or To Baltimore Mary	
Balti	permit. I Departm Importal any inju		21. engagure of Funeral Service Licensee	<sup>2</sup> 2. Name and Address of Figure 1: Lassann Funeral Home I: 7401 Belair Road Balti:	nc		
1/00	Physician and physician and physician and physician the prival-transit	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unitarity in Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Due to (or a	): A	or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 687	v requires that the death certificate been signed by the attending phys should be detached for use as the	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   4   Pregnant at time of death   9   Unknown   U	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
	equires that en signed b ould be deta	ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the Rheumatoid Arthritis; B			bacco use contribute to the	
al Reco	las 2	Completed		,		prior to co med? death? 2 No 1 ☐ Yes	psy findings available mpletion of cause of 2  No
Division of Vital Records,	ng Phys fter this meral di	ation: To Be	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	me of 28c. Injury at	me 5 Reside	ee) ence 6	iy)
Divis	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Towr		
	the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.  29b. Signature and fittle of certifier	death occurred at the time, date and place, for investigation, in my opinion, death occurr	ed at the time, d	late and place, and due to	the cause(s)
•	~ .\ ~ .\		30 Name and address of person who completed cause of death (Item 23a) (To	H24869		lod. Date signed (Month,	9
\	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	ankin Square or	· Baltr	nre, mi)	21237

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Doris Elwell 5:09 PM M October 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner North Arundel Nursing & Rehab Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 21 F 215-30-6962 75 June 25, 1934 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow il Hygiene. other than "natural", or itama 23a or 28a-f ahov vent, the Madical Examiner must be notified at MD Anne Arundel 1 ☐ Yes 2√ No glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Hospital Drive 21061 Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: white Š 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Important: If Item 27 is marked other til any injury or other fraumatic avent, the once. 12 O nursing aide healthcare 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Elwell Jr/son 414 Smith Avenue Evanston, WY 82930 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 Nother (Specify) in state 21. Sign turn of Funeral Pryice Licen 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 rector Baltimore, MD 21201

23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hdvan Coo Physician /Medical Due to (or as a consequence of): Examiner Section tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and physicien are the burial-t Due to (or as a consequence of): O. Box 68760. Physician/Medical ettending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) deteched 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed?
Yes 2 No 1 ☐ Yes No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 3□ DOA this : After thi 27. Manner of Death 1- Anatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No efter death Diractor: / d in by the f 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) October 14, 2009 51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koad a val now 7845 Dakwood park 31. Date filed (Month, Day, Year) 2009 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Maryla		cate of D			g. No. 2009	3449
sician edical	1. Decedent's Name (First, Middle, Last) Andrea Lagina Everette				2. Date of Death Month DCTOBER	Day Year	3. Time of Death 9 12:420M
miner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Ce		City, Town, or Lo	ocation of Death	ויי	4c. County of Deat	timore
ral tor	215-84-7291 1 M 2 F 4			f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreig untry)
'n		City, Town or Location	1		•	,	10d. Inside City Limits
Director	10e. Street and Number 7410 Kirtley Road	10	f. Zip Code 21224		10	g. Citizen of What Co	
oleted by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes	Decedent of Hisp , specify Cuban,	vanic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	e, etc.
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N	of work done dur OT use retired)	on ing most of workin	ig	6b. Kind of Business/	ndustry
a	17. Father's Name (First, Middle, Last) Rayvon Everette	Joodii	18	8. Mother's Name anice E	(First, Middle, Ma	aiden Surname)	
0	19a. Informant's Name/Relationship (Type. Print)  Janice Everette	1				City or Town, State, 2	
		p. Place of Disposition cemetery, crematory		11/4		oc. Location - City or andsdowne	
once.	21. Signature of Funeral Service Licensee	22. Nar	ne and Address	of Facility Wes	ley Cha	avis, JR. imore, MD	
an al er	23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a cons	CEMIA	mode of dying,	such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death 5DAYS
e e	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a cons						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  1. 23c. If yes, outcome of pregnant at time of pregnant at	etal death 3 Ecto	pic pregnancy er (specify)			23d. Date of del Month	ivery Day Year
d by Ph	Part II. Other significant conditions contributing to death but not n	esulting in the underly	ing cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Completed					24a. Was an autopsy performs	prior to o	topsy findings available completion of cause of
Medical Certification: To Be Completed by Physician/Medical Examin	27. Magner of Death 1 28a. Date of Injury (Month, Day, Year) (Month, Day, Year)		DOA Other: 28c. Injury at Work?	t 2		ice 6 ☐ Other (Spe	cify)
Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, street, facility)		s 2 No 2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exami	knowledge, death occi ination and/or investig	rred at the time, ation, in my opin	date and place, a ion, death occurre	and due to the car ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier		29c. License n		290	d. Date signed (Mont)	n, Day, Year)
	4/11		D589	744		10/491()	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death LAWRENCE Thones JEROME 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SINAL HOSPITAL OF BALTIMORE BAUTHORK BUTHORE 8. Date of Birth 06/04/1939 Birthplace (State or Foreign Country MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Months Days 1**X** M 2□ F 219-26-4630 70 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3936 SETONHURST ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BEN ETTLIN **ROSE** CAPLAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3936 SETONHURST ROAD, BALTIMORE, MD 21208 NATALIE ETTLIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 10/25/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK + hours SETTC Due to (or as a consequence of): SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month Day Year use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 6 ☐ Other (Specify) rv occurred

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the once

**Physician** 

/Medical

**Examiner** 

Director

Funeral

à

Completed

Be

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**Funeral** 

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar is used to notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar signed by the a

Division of Vital Records, P.O. Box 68760,

ian/Medical after death

Director: / n 24 hours aft e Funeral Di letely filled in

in the past 12 months?  1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Yea
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed?  1 □ Yes 2 No 1 □ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
25. Was case referred to medical examiner?	Hospital: Other:	eath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and pla miner: On the basis of examination and/or investigation, in my opinion, death oc and manufer/stated.	ce, and due to the cause(s) and manner as stated.  curred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signat

title of certifier

Hours

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINUM HOSPITAL

29c. License number

511 52000

29d. Date signed (Month, Day, Year)

within 24 ho To the Fune completely f

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8760
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Box
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Records,
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Division o
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Robert Furcron  4a. Facility Name (If not institution, gives the following of the following	re street and number) (A) of BA	last birthday) If Under	Town, or Location of Death	October	Day Year 18 2000	3. Time of Deat		
4a. Facility Name (If not institution, given STNAT HOSPE) 5. Social Security Number 723-01-4394  Usual Residence of Decedent 10a. State  10b. County	TAI OF BA  Sex 7. Age (In yrs.	last birthday) If Under	altimore	October	18 2000	. 10		
5. Social Security Number 723-01-4394 10s. State 10b. County	TAI OF BA  Sex 7. Age (In yrs.	last birthday) If Under	altimore	City	4c. County of Deat	h		
5. Social Security Number   6. S   723-01-4394   1   1   1   1   1   1   1   1   1	Sex 7. Age (In yrs.	last birthday) If Under	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4				
723-01-4394 1 Usual Residence of Decedent 10a. State 10b. County	IN WOLLE	Months	1 Year If Under 24 Hrs.	8. Date of Birth	9 Birtl	hplace (State or For		
Usual Residence of Decedent 10a. State 10b. County	,,,	Yrs.	Days Hours Min.	Month, Day, Yea	ar) Co	nsylvania		
				1				
FID	10c. Cit	ty, Town or Location				10d. Inside City Lin 11√2 Yes 2□		
10a Chant and Number		Baltimore 10f. Zip	Codo	100	Citizen of What Co	21		
109. Street and Number <del>9833</del> Park Heights	s Avenue	101. Zip	21215	Tog.	USA	untry :		
	12. Was Decedent Ever in U.	.S. 13. Was Deced		pecify Yes or No-	14. Race - Ame	rican Indian,		
1 ☐ Never Married 2 🔀 Married	1 ∐Yes 21∑ No		v	o Rican, etc.)	Black, White	e, etc. lack		
3 Widowed 4 Divorced	Year or Dates:	To res 2	— No Зреспу.					
		(Give kind of world	k done during most of wor		. Kind of Business/	Industry		
Elementary/Secondary (0-12)	College (1-4or 5+)		•		1 .1			
17. Father's Name (First, Middle, Last.			4			iing		
, , , , ====,				ry Lou Fur	cron			
19a. Informant's Name/Relationship (	Type. Print)	19b Mailing Address				Zip Code)		
Alma Furcron/spor	use					21215		
		Place of Disposition (Nam cemetery, crematory or ot	e of her place)	Date 20c.	Location - City or	Town, State		
4 Donation 5 □ Other (Specif	(y) n							
21. Signature of Euneral Service Licer RONald S	Wade, Director	r State A	Address of Facility	d 655 W. B.	altimore	Street		
soul !!	ac	Baltime	re, MD 2120	01				
shock or heart failure. List only	one cause on each line.		21			Approximate Interval Betweer Onset and Deatl		
disease or condition	u		Bleedi	ng				
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Finer Underlying  Due to (or as a consequence of):								
Cause, Enter Underlying Cause (Disease or injury	C							
	Due to (or as a consequence	uence of):						
-	d							
IF FEMALE:	220 If you systemf	anav						
23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	al death 3 🗌 Ectopic pr			23d. Date of del Month	livery Day Year		
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of c 9 ☐ Unknown	Jeau 5 □ Other (spe	юпу)					
			_	23e. Did tobacc	co use contribute to	the cause of death		
Atheroscier	etic Hear	RI Dis	ease	1 □ Yes	2 □ No 3 □ Pr	robably 4 Unkn		
Hyperiens	iun		_	24a. Was an	24b. Were au	utopsy findings avai		
					prior to death?	completion of cause		
			26. Place of Dea		TO Tes	2 LJ00		
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3 □ DO	A Other: 4 I Nursing H	lome 5 Residence	e 6 ☐ Other (Spe	cify)		
27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)			28d. Describe how in	njury occurred			
2 ☐ Accident investigation	0	M	1 ☐Yes 2 ☐No	0011				
4 Homicide determined	28e. Place of injury - At no		OTHCE			urai Houte Number,		
29a. Certifier 1X Certifying Ph	hysician: To the best of my kno	owledge, death occurred	at the time, date and place	e and due to the cause	e(s) and manner of	s stated		
(Object and a Continuing Fi	miner: On the basis of examina and manner stated.	ation and/or investigation,	in my opinion, death occu	irred at the time, date	and place, and due	e to the cause(s)		
(Check only 2☐ <b>Medical Exa</b> r one)	and marrier stated.				Date signed (Monta	h Day Yearl		
(Check only 2 ☐ Medical Exar	Mild mariner stated.	29c.	License number	29d.	Date orginal (monit	ii, Day, Toar,		
(Check only 2 ☐ Medical Exar	L MN			29d.	cT 18	2009		
(Check only 2 ☐ Medical Exar	om (	D	SYSS8	29d.	cT 18,	2009		
(Check only 2   Medical Exar	om (	D		Spital	of BA	2009 11tmor		
1 2 2	3   Widowed 4   Divorced    15. Decedent's Ec. (Specify only highest grain in the past 12 months?	Armed Forces?   Armed Forces.   Armed Forces.   Armed Forces.   Armed Forces.   Armed Forces	1   Never Married   2   Married   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   Year or Dates:   16a. Decedent's Usual (Give kind of work life. Do Not use   17. Father's Name (First, Middle, Last)   16a. Decedent's Usual (Give kind of work life. Do Not use   17. Father's Name (First, Middle, Last)   17. Father's Name (First, Middle, Last)   18a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address   18b.	1   Never Married   2   Married   1   Yes   2   No   1   Yes   2   No   3   Wildowed   4   Divorced   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of work for during for called for formed formed for formed for formed	Armed Forces*   Armed Forces	College   Contractor   Comparison   College		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** FARMER 512. ROBERT 2009 OCTOBER 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner EALTIMAKE TUnder | Year | IFT BAYVIEW MEDICAL JOHNS HOPKINS CENTER Birthplace (State or Foreign Country) der 1 Year | If Under 24 Hrs. hs Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** Days Months 1 🔀 M 2 🗀 F 87 PA Feb. 10, 1922 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 XYes 2 No Baltimore MD Director Citizen of What Country? 10e. Street and Number 2533 Popes Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 ☐Yes 2 No Specify: Black 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, Its Max Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Welder 17. Father's Name (First, Middle, Last)
Charles Farmer 18. Mother's Name (First, Middle, Maiden Surname) Be Katie Mae Farmer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1661 Cliftview Ave, Baltimore, MD 21213 19a. Informant's Name/Relationship (Type. Print) Jacqueline Jones 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hills Cem 20a. Method of Disposition Middle River, MD Burial 2 Cremation 3 Removal from State 10/29/09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityWesley Chavis, Jr.FH 21. Signature of Funeral/Service Licensee 2007 Eastern Ave. Baltimore, MD21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 17 HOURS HEMORRHAGE SUBARACHNOLD disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **V** No Hospital: 1 🔽 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1 Natural To the nosperation 24 hours after death.

To the Funeral Director: After the funeral pite fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie M.D. RES-000 2009 OCTOBER address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

Registrar DHMH 17 Rev 1/2001

State

Cheng

Jennifer

31. Date filed (Month, Day

5.

242

32. Registrar's Signature

my.

MO

BALTIMORE

21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 22 Pay 2009 ar **Physician** FISHER 4:05 A LAURA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE 2212 SUGARCONE ROAD 9. Birthplace (State or Foreign CZECHOSLOVAK I A 8. Date of Birth 11/15/1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F 82 182-24-0205 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examilier must be usuffiled at once. BALTIMORE 1 Yes 2 No BALTIMORE MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21209 Funeral 2212 SUGARCONE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: à WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL OFFICE MANAGER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ISRAELOVICH **ACKERMAN** MALVIN ARMIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 SUGARCONE ROAD, BALTIMORE, MD 21209 19a. Informant's Name/Relationship (Type. Print) ROBERT FISHER/HUSBAND 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK10/25/2009 RANDALLSTOWN, MD 22. Name and Address of Facilit SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS **Physician** METASTATICOVARIAN CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transh Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 □Yes 2 □No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HUPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier 140 soll

DOOSH653

October 22,2009

09-08159 Sin

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicial Examin  Examin  uneral rector	n/ ner	1. Decedent's Name (First, Middle, Sinkoh  4a. Facility Name (if not institution,	Guitho			-			
rector		4a. Facility Name (if not institution,	ou id M				2. Date of Death Month Day October 21, 2		0708 hrs
rector	_	5637 Ready Avenue	give street and number)		4b. City, Town, or L Baltimore	ocation of Death		4c. County of Deat	A
			7. Age (I	n yrs. last birthday) <b>59</b> Yr	Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth (MI) Dec 31,	Forei	rthplace (State of pgo gn Rassap puntry) Toqo
sho	Director	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Loca	1				10d. Inside City Limits
s 23a or 28a-f show s e notified at once,		10e. Street and Number	-1 · O · ·	Dai	10f. Zip Code	2	10g. C	Citizen of What Coo	intry?
tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatie event, the <u>Medical Examiner must be notified at once</u>	Funeral D	5637 Kead  11. Marital Status  1 Never Married 2 Mar	12. Was Decedent Ev		as Decedent of Hisp Yes, specify Cuban,			14. Race - Ame White, etc.	rican Indian, Black,
ıral", or it niner mus	ক্র	3 Widowed 4 Divor	1 Yes 2 ted If Yes, Give Year or Dates:	1_	Yes 2 No		ork done 16h	Specify: B	lack
Hygiene. I other than "natural the Medical Examin	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5+)	during i	most of working life. I				of Tourism
and Mental Hygiene ?7 is marked other t natic event, the Met	Be Con	17. Father's Name (First, Middle, L	ast)			8.Mother's Name (	First, Middle, Maid	en Surname)	•
h and Men 27 is mar imatic eve		19a. Informant's Name/Relationshi Bathelenew	Pobee - So			and Number or Ru	ral Route Number,	City or Town, Star	e, Zip Code) ND 21212
± = ±		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from State	20b. Place of Dispo	osition (Name of cem other place)	etery,		c. Location - City of Bath'm	
Department Important: injury or otl	-	4 Donation 5 Other See 21. Storture of Funeral Secret		19+,2101 122.	Name and Address		vell Fu	reral	Hone MD21201
sician edical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and							
miner	1	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):  Atherosclerotic Cardiovascular Disease							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  b. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):							
and - transit	I Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.							
ysician au burial - t	ledical	UNPENDED	X AMENDED I tem#		perFH,C897	,11/19/09,V	VS.	23d. Date of delive	
e attending phy for use as the b	cian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	4 Pregnant at tin	2 F	Fetal death 3 Deter (Specify)	Ectopic pregnar		Month	Day Year
d by the at		Part II. Other significant condition	9 Olikilowii	ut not resulting in the	underlying cause gi	ven in Part I.			o the cause of death?
seen signed	eted by			<del> </del>			24a. Was an	24b. Were	obably 4 Unknown autopsy findings available completion of cause of
cate has l	Completed						autopsy performed 1 Yes 2	d? death?	
certificate ector, page	Be	25. Was case referred to medical examiner? Legal 25. Mac of Death (Check only one)							
After this funeral dir	위	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year			- '	Home 5 Res 28d. Describe how	injury occurred	er: Scene
within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ation	1 Natural 5 Pendir 2 Accident Investi	ng igation			es 2 No			David Barrier City
hours after death ineral Director: y filled in by the	Certification:	4 Homicide determ	not be	y - At home, farm, str	eet, factory, office bu	Jilding, etc.	or Town, State		Rural Route Number, City
within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	Σ	29b Signature and title of cortifier	te Week	12080	O.C.N			od. Date signed (A October 21, 20	
		30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Sta	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	Kal				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ered ITH 2009 1+01 CTOBOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNRISE SOVERNA SSISTED 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1918 Missouri If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days 495-14**-**6338 1**X** M 2□ F Yrs 91 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedlen Example and profiled at once. 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Maryland | Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21146 Funeral 43 McKinsey Rd. 12. Was Decedent Ever in 19942 -Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1961 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2X No Specify Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Lavina Davis Glenn Gholson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9304 Harness Horse Ct., Springfield, VA Randall Gholson, Son 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Oconee, Chematory of other place) Remortial Park Cemetery 20c. Location - City or Town, State Oct. 29, 2009 Seneca, SC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Old Town Funeral Choices 21. Signature of Funeral Service Licensee 1205 Belle Haven Rd., Alexandria, VA 22307 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** YEARS ARKINSONS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit be executed Due to (or as a consequence of): 68760-Physician/Medical The law requires that the death certificate the' attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 s death? 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 NO Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

OCT 28 2009

ETERANS HIGHWAN MUSSILLE M